STATE OF MARYLAND

ADVISORY COUNCIL ON PRESCRIPTION DRUG MONITORING

HOWARD COUNTY HEALTH DEPARTMENT
7178 COLUMBIA GATEWAY DRIVE
COLUMBIA, MARYLAND 21046

FEBRUARY 27, 2009
9:30 a.m.

BEFORE THE HONORABLE JOHN F. FADER, II, Chairman

SPECIAL AGENT MICHAEL A. SPONHEIMER, Presenter

Reported by: KENDI IRWIN, CSR

ALSO IN ATTENDANCE:

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| DR. J. RAMSAY FARAH | LARAI FORREST, ESQUIRE |
| DR. MARCIA D. WOLF | DR. ROBERT L. LYLES, JR. |
| DORCAS ANN TAYLOR | DR. PETER COHEN |
| DR. DRVANG H. GANDHI | BRUCE KOZLOWSKI |
| LINDA M. BETHMAN | GEORGETTE P. ZOLTANI |
| MICHAEL J. WAJDA, MS,JD | MARY JOHNSON ROCHEE |
| DR. NICHOLETTE MARTIN-DAVIS | HENRY S. CLARK, III |
| JOHN J. MOONEY | GAIL AMALIA B. KATZ |
| GWENN HERMAN | TONI CARTER-RADDEN |
| JANET HART | GLEN HARPER |
| JAMES DOLD | MIRIAM GREENAWAY |

(Whereupon, the meeting of the Advisory Council commenced at 9:30 a.m.)

JUDGE FADER: Let me say good morning to you and thank you all very much for coming. Unfortunately Joe Curran called me yesterday afternoon, he is a little bit under the weather, nothing serious. Instead of giving orders, which he has done all of his life, he is taking orders and staying home because the doctor told him to. But he is very much looking forward to a future meeting.

LaRai Forrest has been the driving force behind us getting our first real dose of practical clinical information. We can talk about all these statutes and how everything works, but LaRai is now going to introduce someone who can give us some clinical insights as to what is going on. And with that, LaRai Forrest, and many thanks for arranging to have the special agent with us.

MS. FORREST: You are welcome. Good morning. This is Special Agent Michael Sponheimer. He is with the Division of the State Police. He is

one of eighteen individuals in Virginia that are able to access the Prescription Drug Monitoring Program. And he is going to go over in detail how he does that, what are the guidelines for doing it, and why it is restricted. He also has looked at our minutes from last week and he has some questions to some of the answers -- or, I'm sorry, some answers to some of the questions that everyone had. He is going to go into detail into all of that, and hopefully he'll be able to explain how law enforcement is able to access to everyone's satisfaction.

JUDGE FADER: One other thing, too. Remember we do have a court reporter here, and she needs to know who you are when you ask questions, and I have asked her to yell at you if you don't say who you are so that we get all of this down for the future. So if she's yelling, it is my fault, it is not her fault, but she just does need you to say who you are.

Trooper, thank you very much.

SPECIAL AGENT SPONHEIMER: Yes, Judge, thank

you. My name is Michael Sponheimer, Special Agent with the Virginia State Police, assigned to the drug enforcement section, drug diversion unit, in Fairfax, which handles all of northern Virginia, Prince William, Louden, Fairfax, Arlington, Alexandria. I'm one of eighteen diversion agents in the State. Each division has between two and three based on the number of counties in that division.

I'm here to talk to you today about the law enforcement aspect of the Prescription Monitoring Program, how we use it, what Virginia's restrictions and requirements are for the PMP. And, please, if you have any questions at any time feel free to ask. If I don't know the answer, I will find out the answer for you.

After reading the minutes from last meeting, I did notice that Dr. Farah had a bunch of excellent questions that I hope to answer for you. There were four that you enumerated, and I hope to answer them. If I don't, please feel free to ask them again. They were excellent questions and that's why I'm here.

They had to do with law enforcement access.

MS. FORREST: He also has his presentation over there. If you haven't gotten it, it is right on the side.

SPECIAL AGENT SPONHEIMER: Just a little bit of background about me. I've been with the State Police for eleven years. I was in uniform for six, and got promoted and did street drugs for a year and a half. And then wanted more of a nine to five, so I went over to diversion. That turned out to be an 8 a.m. to 10 p.m. job because of all the complaints and work that was required.

What I'm going to talk about today -- excuse me for having my back to you. I'll try not to. Goals and objectives of the Prescription Monitoring Program and how Virginia includes those in the restrictions in the Codes in the Virginia courtroom. Description and overview of the program, Virginia's reporting requirements, who we require to report when, how, what drugs, what schedules, and things of that nature. Again, Virginia's laws and regulations regarding the

PMP, how I access a report or how a practitioner or dispenser would access a report, how I use a prescription monitoring report, and the restrictions that are placed on me as a law enforcement officer, how I can use them and when I can and cannot access a report, how the information is secured, how it is kept confidential. That's a big concern about secondary dissemination, people who don't have the right to look at that, or violations of privacy. I'll go into how I keep it secure and our policies and procedures on that. And then some general design and construction elements to think about, that I thought might be discussion points for the group later on. And some statistical data regarding Virginia's Prescription Monitoring Program.

The goal, I guess, of a Prescription Monitoring Program first off would be to assist health care providers and law enforcement to identify, treat and prevent Rx drug abuse. First goal should not be to lock up the bad guy; it should be to help a patient get better if they are abusing. That's my philosophy

and that's how I guide my investigations as well.

Identify and investigate unlawful drug diversion. That means to promote in the Code a balance between the health care provider and the law enforcement officer who is going to use this. There needs to be a collaborative effort, not one hand stonewalling the other. If we both work together the goal of what everybody is trying to accomplish can be done.

And also to provide real-time access to the prescription drug data by prescribers and dispensers. To assist with the identification and treatment, some ways that I would -- how Virginia does it, is allow prescribers and dispensers 24/7 access to the program with a very rapid turnaround time. Virginia is in the process of implementing software that would do exactly that, provide dispensers and prescribers twenty-four hours and a day, seven days a week access to that. And the turnaround time, they hope to have it in one to two minutes. If you as a dispenser are standing behind the counter and you have someone who presents a

script, and you think that's not right, you run a report, in one to two minutes find out where exactly they're getting the drugs, if they're doctor shopping and so forth.

JUDGE FADER: Let me just stop you there and ask you a question that's foremost on everybody's mind. That doesn't allow you to surf the --

SPECIAL AGENT SPONHEIMER: Absolutely not.

JUDGE FADER: In other words, you have to have a specific name to be put in at that particular time and you have to have identifying data if at all possible, such as age, birth date, something of that sort?

SPECIAL AGENT SPONHEIMER: Absolutely. I'll go into that later. As a dispenser, if they have a name, date of birth, and address, they can search the database for it. Also, Virginia does proactively monitor their prescription data for signs of abuse, as the criteria were developed by prescribers and dispensers, not the police. The police had nothing to do with what would be signs of abuse.

Also, to provide a widespread PR campaign to inform dispensers and prescribers of the existence of a Prescription Monitoring Program. I speak to many prescribers who don't know the Virginia program exists, don't know they can access it for their patients.

Virginia currently at this point has a requirement in the statute that the prescriber must obtain the patient's consent before they conduct a query of the program on that particular patient. The General Assembly has approved unanimously to remove that part of the statute, so that prescribers do not have to have a patient's consent before they query the program on that patient.

Last one is law enforcement is not equipped or trained to handle treatment. That's the practitioner's job, not law enforcement.

To identify and investigate unlawful drug diversion. I would put forth and submit you should provide law enforcement access to the prescription program. A couple things to consider in doing that is

does law enforcement officer need real-time access or 24/7 access. I would say no. This is just my opinion. We usually work nine to five, give or take. We can run it during that time. We don't need -- on Saturday morning if we get a complaint of a prescription fraud, we don't need to know at that time. Again, my personal opinion. And these are just some things to consider.

I would insure that the Prescription Monitoring Program covers drugs with a high potential for abuse, Schedule II, III, and IV, and that's what Virginia covers, reported to the Board of Pharmacy.

Should provide law enforcement with the same information provided to medical personnel as regarding patient name -- on the report: Name, date of birth, prescription number, pharmacy, things of that nature. It should promote cooperation between law enforcement and the medical community. The goal would be, again, treatment for those who are addicted and abusing prescription drugs, this is what this is meant to prevent. If it can't be prevented, then the police

should step in and make arrests as probable cause exists.

Should promote a balanced use of information. Again, the main goal of any prescription program should be to prevent the drug abuse and diversion. And I guess for this, more emphasis should be placed on the frontline persons using the PMP frequently and often, as practitioners and dispensers should use it often, to check patients that they think are doctor shopping or have a suspicion of.

Should make it a requirement that law enforcement have an active criminal investigation before a query can be conducted. I can't just query one of your patients because you tell me that you suspect as a practitioner that they're doctor shopping, if there is no active criminal case open. It has to be some sort of complaint, and a case is opened, and then a query is conducted.

MR. WAJDA: What would trigger a so-called active investigation?

SPECIAL AGENT SPONHEIMER: If a practitioner

calls and says, I just had somebody using this name, date of birth, and address, Giant Pharmacy, passed a fake script or attempted to pass a fake script, there would be a criminal investigation.

JUDGE FADER: Now, that is a call that is made to the Police Department?

SPECIAL AGENT SPONHEIMER: That is correct.

DR. WOLF: This goes along the same lines. Why do we need a database to be able to work with law enforcement? And yet from a physician perspective attempting to bring law enforcement in when I have suspicions basically has me hitting my head against a brick wall because what I have is hearsay or there is no criminal complaint and I'm not in a position to make a criminal complaint because what I have is very highly suspicious, but it is not necessarily a criminal act, a person caught in a criminal act. Why do you have to have a database to work with us?

SPECIAL AGENT SPONHEIMER: It is not absolutely one hundred percent.

DR. WOLF: It is not happening.

SPECIAL AGENT SPONHEIMER: As a practitioner, you can be a complainant and you should be a complainant. If you receive a complaint of prescription fraud -- because they may have your name and DEA number and they may be out there passing a thousand scripts and having those scripts and selling them. Without that information, without the database, law enforcement may not be able to investigate as fully.

DR. WOLF: That's clearly a criminal act that we would have access to knowledge of when the prescription is presented to us. But I'm talking before it gets to that point, whether they're doctor shopping, whether they're making the rounds. Working with law enforcement in the past has -- behind the scenes I guess it is probably somewhat effective, but at least on the surface of it, they can't do anything with the information.

SPECIAL AGENT SPONHEIMER: What information do you mean?

DR. WOLF: I have called State Police, I've

called local police, this person is intoxicated, this person is positive for cocaine, this person I think is selling their pills on the street. I have no proof of it, but I'm highly suspicious that that's exactly what happened. Or they got it through the Internet and they admitted it or they bought it off somebody down the street and admit it. I've taken this information and presented it to law enforcement, and they basically said we can't do anything because you have no proof that that's actually what occurred.

SPECIAL AGENT SPONHEIMER: And they're exactly right.

JUDGE FADER: We don't have any money in the budget for a thirteen year old to maintain this technical equipment.

DR. FARAH: But I think I have a very good source for you. It is a no-brainer.

JUDGE FADER: And of course the situation with my wife as a pharmacist is the same thing. She makes telephone calls, and she's made them to the Board, and she has also made them to the Baltimore

County Police, and they have said to her they can't do anything about this. Now, of course, it is her responsibility and right to make the call, but it is also your responsibility and right to determine when an investigation should occur, and what I think Dr. Wolf is saying is that she is less than fully happy with the way that the police have picked up on things that through her experience are telltale things that should be investigated.

SPECIAL AGENT SPONHEIMER: You bring up a very good point. I think as a practitioner, if you have a patient who is positive for cocaine, you handle that the way your training and experience dictate, however you would handle that. But for us, for law enforcement to get involved, the only thing I could probably do is go and talk to the patient and say, where did you get the cocaine from, and go from there. But there would be no proof or no evidence, so no prosecution could occur. Or if they bought pills down the street, they can tell me that, yeah, Sally sold me the pills in this house, but unless they agree

to become a source of information, go into the house and buy the pills from Sally, no prosecution can occur because the evidence is gone. Internet pharmacy is our concern, and that would be a long-term investigation on an Internet pharmacy.

JUDGE FADER: But we do have the Maryland State Police here listening to us today. So perhaps with Dr. Wolf's statement, something needs to be done in the future for what she is saying and what some other pain management physicians are saying, in exchange with the local police and the State Police, as an exchange of ideas as to what she feels should be investigated, as to what you feel should not, so that you can have some sort of exchange about this. What do you think?

MR. MOONEY: We can always look into it.

JUDGE FADER: It depends upon what she is saying.

MR. MOONEY: Right, and I agree with the Special Agent, it is very difficult to look into it unless we're going to drag you into court as a

witness, and I know you don't have time to do that all the time, and I would love to be in Virginia State Police's position with eighteen drug diversion investigators. Maryland State Police doesn't have a drug diversion unit. I have seventy investigators in the drug enforcement division, and he has got a quarter of that just in diversion.

JUDGE FADER: Well, one of the reasons I see that the talk that you are generating is important, because whatever the exchange is, then that gives Dr. Wolf an opportunity to yell and scream at her State senator and delegates and other people that could listen to say, you know, you have got to do something about that, we're cooperating.

DR. WOLF: I actually have gotten some cooperation from the State Police, more so than any of the local jurisdictions, but it has not been an active necessarily investigation, that they have been very helpful, there are things that have occurred behind the scenes, but it hasn't been on the surface.

DR. FARAH: As this august body is

deliberating, it makes sense for us to have a laundry wish list, as we go along and we are going to end up with a recommendation at some point, we point out those areas that need to be addressed to make whatever we end up with work. If one of these things are going to require that we need to look at resources and other ways of doing things, we should point it out, have a list of these things, and then we can reprioritize how this at the end of the day is going to come together and work.

JUDGE FADER: I'm making a note of that, because Marcia is going to have to sit down and say, hey, I've done this, I've done that, the police have done nothing, what are you going to tell me. And I think you and Dr. Lyles probably has some stories along that line, too. We'll make a note and we'll pick that up and have an interexchange with the police.

This gentleman is a concerned citizen and I got your name, but I forgot it.

DR. HARPER: It's Harper.

JUDGE FADER: How do you spell that?

DR. HARPER: H-A-R-P-E-R.

JUDGE FADER: Okay, Mr. Harper.

DR. HARPER: How does a physician in the State of Virginia handle this problem: If the physician is a pain management physician and does his duty and gets periodic drug screens, random, unannounced, and cocaine is found in the person's urine, is that evidence that could lead to legal actions and should -- and what happens if a physician in the State of Virginia so reports, because it is an illicit substance, it is unlawful, it is in the person, they are guilty of having it in their possession and in their system. To me I think this is very pertinent. What does a Virginia physician do at this time?

SPECIAL AGENT SPONHEIMER: They have a number of options they can do. They can dismiss him from their practice.

DR. HARPER: Well, that's obvious.

DR. WOLF: But that's also malpractice.

DR. HARPER: I'm talking solely now from the legal aspect.

DR. WOLF: They clearly have some addiction problem and/or some other behavior problem, and they need to be treated medically for that as well. I don't have to give them controlled substances for their pain, and I don't have to give them their drug of choice. I can treat them with other anticonvulsants or whatever, but I think it is malpractice to discharge them under those circumstances without attempting to make treatment.

DR. FARAH: May I give an example? This happened to me yesterday. I got a call from a family physician, and she said, I've been asked to do the pain management on this patient, referred by a pain specialist for that matter because this patient needed other things. And they did a urine test and sure enough this patient did have cocaine. And you are an addictionist, I would like to make sure you follow up with this patient because I understand you have seen this patient a couple years ago. I say, no problem,

and I called the patient and they have an appointment for Monday. But this is a person who got 180 tablets of Dilaudid. He went to another pharmacy, got another 200 tablets of OxyContin. And there is no way this patient could have had all this medicine for osteoarthritis of the knee and have a legitimate excuse. She did the urine test and sure enough there was no opiate in the urine. So this is a classical case where the patient is going shopping, he is obviously selling the medication, he is not even taking the stuff. These are the settings, and so I did survey CVS, I called CVS, and they did fax me all the different CVS pharmacies, and I have six pages full of all the different prescriptions that this patient had received with negative urine for opiates, positive for cocaine. This is a classical addiction patient with diversion that we have to address.

The reason I bring this example is because also on Wednesday we disciplined a physician for having had access to the medical records of a patient who is not his. And so if I am a doctor in my office,

and I can call CVS and they send me a whole list of all the medicines that this person has received with the pharmacy not having any proof that I am the doctor of this patient, that he is a registered patient, how are we going to balance this with people having access to medical records?

JUDGE FADER: Just a second now. I've got to protect my pharmacists because in pharmacy school we teach them that if this physician calls with a legitimate inquiry with regard to a patient, that the Medical Records Act of the State of Maryland allows them to have access to that. Remember that, Ann?

MS. TAYLOR: Yes.

DR. FARAH: I'm very grateful, otherwise I wouldn't have managed. But how do I balance --

JUDGE FADER: But the situation is that pharmacist has a responsibility to make sure you are who you say you are and why you want those records. As soon as that pharmacist makes that decision, the pharmacist can turn over the records to you. So it depends upon what you said to that pharmacist.

DR. FARAH: And I have no problem with that.

JUDGE FADER: I have a feeling that you said enough that allowed them to conclude that you were legitimate.

DR. FARAH: And that physician who had access to the medical records of an employee who he wanted to make sure what she was taking or not taking was not her doctor and of course we disciplined him.

JUDGE FADER: And that's absolutely correct.

DR. FARAH: And we threw the book at the guy because of access. But when we're talking of tracking and we're talking of balancing, I need your help on how you address this so we make sure that the proper person -- or if the improper person accesses the data, we get the information to protect the citizens.

JUDGE FADER: The pharmacist is supposed to record in that pharmacy database, according to what they're taught, exactly who called and what you said and what records they gave. And we tell the pharmacist, because I teach this, since '74, you call back, you make sure this is a verified number, you

listen to this --

DR. FARAH: How long do we keep this information and where does it go?

JUDGE FADER: Five years is required in the State of Maryland that it is to be kept in the system. Most pharmacists keep it more. But once again, that pharmacist can do that and is supposed to do that, if you convince that pharmacist that you are legitimate and that you have a reasonable inquiry. If the pharmacist got a call from a podiatrist, the pharmacist would not be allowed to give that information.

SPECIAL AGENT SPONHEIMER: Sir, to get back to your original question, law enforcement is not in the business of telling practitioners how to do their job. That's not us. We would simply receive a complaint and act on it based on our training and policies and the State law. To follow up on the example, if a physician had called me and said this person is negative for opiates and positive for cocaine.

DR. HARPER: Let's say they are positive for both opiates as well as cocaine.

SPECIAL AGENT SPONHEIMER: That means they are probably taking their prescribed medication as well as cocaine.

DR. HARPER: Still an illegal substance.

SPECIAL AGENT SPONHEIMER: Absolutely. In the State of Virginia it is a felony for them to possess a Schedule II drug without a valid prescription. But, I guess, prosecution wise, to go and arrest them, there isn't enough probable cause because there is no evidence. The evidence is the actual cocaine itself, or the urine, not the lab sheet that says there is cocaine in the system. In Virginia that would not be admissible in the Court as possession.

DR. HARPER: I'm not arguing, sir, but the Ameritox drug screen said it is in their urine.

SPECIAL AGENT SPONHEIMER: Absolutely.

DR. HARPER: Wait a minute. To me that's proof positive that the person ingested it.

SPECIAL AGENT SPONHEIMER: But that's not a State certified lab. There are a lot of intricacies that have to be met. However, we could always go to the patient and say we received a complaint, where did you get the cocaine.

JUDGE FADER: LaRai, it has been a long time since I tried one of these cases. Years ago just the mere presence in their bloodstream was not enough to arrest them for anything. I don't know what the law is today. You are the prosecutor.

MS. FORREST: If you haven't seen them ingest, while it might be in their system, it is not something the State is going to prosecute. You need to have actually have possession of it. Short of -- yes, it is in their body, but you haven't seen it done, other than them admitting to it. And the likelihood of the State proceeding on that is I'm going to say none. It is not going to happen.

JUDGE FADER: And my recollection is years ago that came about because of a Supreme Court opinion that said it wasn't enough, but I'm foggy on that.

DR. FARAH: I would back this up, because there are studies made where police officers were given money to handle and they turned out positive in their urine for illicit drugs. So it is definitely not a forgone conclusion, that if you have a positive urine for a drug, that necessarily I have ingested it, whether it is hair, or exposure, and handling it.

MS. FORREST: That's very true.

SPECIAL AGENT SPONHEIMER: Just to get back to your question, Dr. Farah, a monitoring program would in the case that you put forth about calling the pharmacy would allow you to directly query the system using the patient's name, date of birth, and an address and receive not only information from CVS Pharmacy but every other pharmacy in the State of Maryland where this patient has gotten and filled a prescription under his name.

DR. FARAH: But it would also track me and find me beyond any shadow that I'm the one who queried, because if I'm doing something that I shouldn't be doing, there should be some kind of check

and balance.

JUDGE FADER: In this new type of system, yes, that would occur. Under the present system it is up to the pharmacist to check on you to make sure you are who you say you are, and to put the note into the computer.

SPECIAL AGENT SPONHEIMER: Every time I query a person, or dispenser, or practitioner, it logs, and says, Agent Sponheimer, this date and time, queried this patient. So if anything ever comes back, why did you query this, I have to have a reason, give a reason why I queried somebody or why I queried a dispenser or prescriber. So there is that check and balance. Because I also have to put in, and I'll go over this in a minute, a case number, a State Police case number that identifies the case for which I ran this report.

DR. WOLF: Do you have to do that before you can get access to the data, or do you just have to do that as part of you looking at it? I mean, in other words, if you don't put that number in will you not be

able to see the data?

SPECIAL AGENT SPONHEIMER: That's correct. I won't get it. And I'll go into how I query the system and how it's returned to me in just a few minutes. But, yes, before it allows me to hit submit, case number.

JUDGE FADER: But LaRai, don't you have to put your name in and access in order to get a criminal record? Somebody in your office has to do that, don't they?

MS. FORREST: Yes.

JUDGE FADER: It is the same thing that prosecutors -- when I was full time on the Circuit Court we had access to all of this stuff, but to prevent abuse if I wanted to use it, my secretary had to put in my name, that I wanted this record from the Motor Vehicle or whatever, so my name was in there and I had better be able to explain why I was getting at that record.

MS. FORREST: Yes. My office, the way it works is usually one or two people are designated.

Usually the records already come to me, but if I'm missing a record or I need an update, we send a request, and one specific person looks it up and gives it to us.

DR. MARTIN-DAVIS: My question is -- maybe you can't answer this, but it sort of goes back to what Marcia was saying. If we as physicians do everything right, and abide by the standard of care, and we give medicines once a month, and we make the patient see us, and we do random drug tests, and now we have done a test and we found something abnormal. You guys are saying it is not a certified lab, that's not enough, so then he goes out with my prescription for OxyContin, and even though I don't give him one that day, I've given him one in the past and he has cocaine in his system. He goes, he gets in a wreck, he kills somebody -- well, Doctor, you did a test, you knew he had cocaine in his system, you are giving him narcotics. Well, it was the narcotics that caused the wreck, not the cocaine.

SPECIAL AGENT SPONHEIMER: That is something

as a police officer I wouldn't get involved with. That would be your best professional judgment as a practitioner on how to handle that situation, and what to do with your patient, and how to care for your patient. Police officers -- and I don't want to get involved in telling a physician how to work. That's not my job at all.

DR. MARTIN-DAVIS: I guess my question is what else can we do? We have done everything we can in terms of trying to follow this patient and make sure we're abiding by the standard of care. Now we found something, cocaine, and we are like okay, we have got a problem here, law enforcement, help us out.

SPECIAL AGENT SPONHEIMER: I don't think you can do anything more. And I don't know as law enforcement what we can do with that because of what we had discussed before.

JUDGE FADER: He goes up to the person and he says, I understand that you had drugs in your system. That's not correct. Well, I think it is.

Well, it is not. I think it is. Well, it is not. That is not proof and he is just trying to explain to you why that is.

SPECIAL AGENT SPONHEIMER: If I can talk to the patient and I say, hey, I'm an agent with the State Police, do you want to talk to me? No, I don't want to talk to you. I can't hold him, I can't talk to him. He is free to go about his daily life. I can't hold him for that. But at least maybe you can -- if he brings it to your attention and then you maybe can change your care, refer him to a specialist for addiction or however you as a physician would handle that.

DR. MARTIN-DAVIS: That part I understand. I guess I'm on my soap box.

SPECIAL AGENT SPONHEIMER: I understand.

DR. MARTIN-DAVIS: Instead of going after him you go after us, us as the physician. He gets in a wreck, now I'm hauled into court because I documented that he had cocaine in the system and he had a pill bottle with my name on it.

SPECIAL AGENT SPONHEIMER: That may be more of a Board issue once you identify the cocaine problem and if you continue to prescribe months and months after that. But if you were doing the standard of care, here's a lab prescription, here's a referral, I can no longer be your physician or however you would handle that, there is no way I can get involved or a prosecutor would.

JUDGE FADER: We can bring some medical malpractice lawyers into this to tell you that the chances -- and defense lawyers and even plaintiff's lawyers the chances of anybody being able to call you on the carpet in that particular situation for what happened there are slim and very, very, very slim. Yes, sir.

DR. GANDHI: Can your database be queried to look at physicians prescribing badly? Can you, instead of looking at patients, can you search by physician's name and look at what they're prescribing and how they're prescribing?

SPECIAL AGENT SPONHEIMER: Yes, but I would

have to have an active criminal case. I would have to have a complainant and a criminal case.

DR. GANDHI: Does this apply to federal agencies as well that they may have access to?

SPECIAL AGENT SPONHEIMER: Yes. I'll go into that in just a minute. If I don't cover your question when I do, please ask me.

MS. ROCHEE: I would like to address just the point and degree of involvement with law enforcement. And this addresses Dr. Wolf's comments a little bit. When we may call in to the State Police, a lot of times we are communicating with each other, we have our network of communication and special agent, he may reach out to DEA to see if this is something we have been working on or know about. You have a patient who is rampantly prescription shopping, there may be a prescription ring, so the patient's name is well-known. So our queries are not random. Generally they are based on some real basis of information. I think that's something that a lot of physicians and pharmacies may not be aware of. And

that probably goes even further to say a lot of doctors and pharmacists are not aware that this database exists in Virginia. I don't know what the means of the Board is getting into in making pharmacists and doctors aware that this exists. But I know that a lot of practitioners and pharmacists do not know that this database exists and they can access it as well.

SPECIAL AGENT SPONHEIMER: You are exactly right. One thing for practitioners and dispensers, you can query the Virginia system. You as a practitioner can query Virginia's system.

DR. WOLF: Us here in Maryland?

SPECIAL AGENT SPONHEIMER: Absolutely. All you have to do is, there is a form, fax it down to the Virginia Board of Pharmacy. They will grant you a user name and password.

DR. WOLF: Do you have those forms?

SPECIAL AGENT SPONHEIMER: I can get them. I can provide them to you, absolutely. But you as a physician can query Virginia's system.

DR. WOLF: Real-time or delay?

SPECIAL AGENT SPONHEIMER: I'll go into that. You get the report back in about 20 to 25 minutes, within an office visit, if you have a patient in there, absolutely. If you need it quick, you can call down, hey, I'm going to submit this request, I need it like now, and they'll be able to provide. They are absolutely wonderful down there. Every time I need something they're on the ball.

Yes, sir.

DR. LYLES: Yes. Bob Lyles. On the depositions that I have reviewed in Virginia, there at one time was a trend that it seemed like the patients were actually driving the investigations of the physicians. The patient's statements: The doctor got me addicted. And that seemed to be one of the prevalent instigation parts to go to the Board. If a patient complains, versus a physician complaint, are you looking at that in Virginia as a different hierarchy of complaint?

SPECIAL AGENT SPONHEIMER: I would say one

patient complaint, oh, I got addicted, that's why I'm forging scripts, personally I would take it with a grain of salt. That's their excuse, that's their justification, that's it. However, if over a period of time through different investigations the same physician keeps popping up over and over, he got me addicted, he didn't perform an exam, it was cash on the table, and I could ask for what I wanted, they didn't do their due care, then a case would probably and likely be opened on that physician, dispenser, or prescriber.

DR. LYLES: They would comingle those cases, though, to see that that trend was developing. Is that something you could draw from the database?

SPECIAL AGENT SPONHEIMER: Reference complaints against physicians? This would not contain complaints. That would just be through paperwork and the internal system, patient referred or complained that Dr. X got him addicted to this, that's why he was forging the scripts because that doctor wouldn't give him enough, and the physician was giving him what that

physician thought based on his medical training was proper for the patient. Once or twice, it is dismissed as a grain of salt, as a justification for a criminal act. If you see a trend happening over the course of different investigations, then a case is opened. And then, only then, could we query what you have prescribed by your name and DEA number.

JUDGE FADER: Dr. Farah, we're going to be calling on you and the Board at some time hopefully to give us some eye view of statistical data as to this and how many cases the Board has had. We certainly can only make an inquiry because your records are confidential for investigatory, we can't get in there, but we sure would like to know what the Board's experience with this is sometime in the future.

DR. FARAH: I can give you a quick highlight. We investigate every single case that comes, no matter where the source is. We don't even ask to be identified. No matter how blind, we look at every single case.

JUDGE FADER: I would suspect that ninety

percent of them end up with nothing.

DR. FARAH: That is correct. They end up with nothing.

JUDGE FADER: And the records of physicians and the inquiries do not appear on the physician's record?

DR. FARAH: If it is negative. If there is anything positive it would be public knowledge and it is printed in our letter that goes out.

JUDGE FADER: Do you think you can get us any idea of statistics over the past three or four years as to how many complaints occurred with regard to drug diversion and things, and how many investigations were done?

DR. FARAH: We probably have the information and I'll make note to take it back.

JUDGE FADER: Let me just stop here for a moment. And our pain advisors are not as rough and tumble as the rest of us, so, Gwenn, do you have anything you want to put in here with any of this, either of you?

MS. HERMAN: No. I'm just listening right now.

MS. KATZ: In terms of balance, we want balanced use of the information. We also want to make sure that the system is constructed in such a way that patient's access to care is not impeded. By that usually it means that the process of writing a script for the kinds of medications that often pain patients need but are highly scrutinized drugs can become so cumbersome that a physician would just prefer to not deal with it, and therefore doesn't prescribe those medications.

DR. WOLF: It gets even more complicated than this. I'm actually going around with High Mark Medicare right now for some patients who are on Medicare but because of disability issues, whether it's MS, or trauma, or whatever, and High Mark at least, Medicare is, but High Mark is not even willing to recognize the fact that there is a risk in prescribing controlled substances in patients who have multiple diagnoses -- either bipolar or other issues

like that. And they are basically saying those levels of care are medically unnecessary. So it is even more complicated.

MS. KATZ: Sure. And that's just an example of how the insurance systems sets all kinds of --

JUDGE FADER: Impossible.

MS. KATZ: Well, very, very, very cumbersome. And for many physicians they say, you know, this will be enough for you and this should take care of your pain. It doesn't. But the physician, even if we're not talking about scrutiny, says I don't want to go through what I need to go through in the system. Then build on that and add the whole concept of scrutiny. That is our concern from a pain patient's perspective.

JUDGE FADER: Gwenn, you indicated to me in our talks that that was your personal experience and the experience of many people that you helped, that you just -- because of this problem with the physicians, and insurance and everything, people just don't get the pain medication they need go.

MS. HERMAN: Yes.

MS. KATZ: Gwenn and I were talking, we're going to bring in the results of a survey that was done of the status of pain in Maryland.

JUDGE FADER: We hope to have a whole meeting devoted to you and your presentation of problems in the future.

I told you on the telephone that this was going to be a feisty little situation.

SPECIAL AGENT SPONHEIMER: That's perfect. Challenge me.

JUDGE FADER: And you got all excited about it, and I'm glad that we are contributing to your excitement.

SPECIAL AGENT SPONHEIMER: I hope I live up to the questions. To answer your question, ma'am, in Virginia, physicians don't have to fill out any extra paperwork. They don't have to query the system unless they want to. It is not mandated. So if you as a patient go into a physician and have a legitimate medical need for high potency Schedule II narcotics

and the physician deems it is necessary, you are going to get what you need. And the physician has nothing else to do with this program. He may query up on your next visit to insure -- to see if you filled it or if that patient is going to another physician and getting the same medication.

MS. KATZ: So let me just finish with that. Let's say I am that patient, I take the script, I go to the local whatever and I fill it, is that when it goes into the system? When does it go into the system?

SPECIAL AGENT SPONHEIMER: I'll get into that in a minute, but if I don't answer, please ask me again. Doctor?

DR. WOLF: Part of what you were saying, and I think that the perception is now that the pain patient comes in -- a classic example is a gentleman I say yesterday. He has got metastatic prostate cancer. He had all his ducks in a row. He had been military trained. But the burden of proof is now on the patients to prove that they are a legitimate pain

patient. By me getting the records outside of the patient I have to go directly to the source of the other physicians. I go directly to the pharmacies and get a list of other medications. I do directly to prove that this man definitely does have metastatic cancer in his bones and everything. What used to be a situation where the guy who had cancer was going to die and we would give him whatever he needed to help his pain is gone. He walks through the door and he is automatically suspicious because he is taking narcotic pain medication. He feels that he is now treated as a criminal rather than a patient.

SPECIAL AGENT SPONHEIMER: That's a perception we need to overcome. As physicians, you know that's not true, and I know that's not true.

DR. WOLF: I know that's not true, but the patients have to jump through a lot more hoops than they did twenty years ago.

MS. KATZ: And some of it is law enforcement and some of it is what you just said about High Mark. Some of it is the payors who also set up a ridiculous

system of scrutiny because a lot of these medications are expensive.

SPECIAL AGENT SPONHEIMER: This will not produce an additional burden on the patient. This would simply allow a tool for you as a physician to say, okay, what other Schedule II, III and IV drugs has he filled. So you have instant access. You don't have to call CVS, Rite Aid, Safeway, Shoppers, all the local pharmacies. You don't have to do that. You have one place to query that to assist you in patient care. It is not to hinder patient care, it is to assist and facilitate proper patient care.

MS. HERMAN: I'm confused now. Why would you even scrutinize him if you believe he has a good medical reason?

DR. WOLF: No. I mean, the gentleman walks in my door, he is not emaciated, he is not in the very last days of dying and hospice. He comes in, he presents himself as a patient with metastatic bone cancer. I've never seen this patient before. I don't know him, I don't know his mother, his sister or

anything. So I start de novo who this patient is. And in the old days, not even old days, but years ago patients may bring their own records. Military personnel often will bring their charts with them, but that's not acceptable anymore. I go to the source directly because they could have adulterated. I have seen where people have come in and tried to scam me and pass me an adulterated record, printed out something and put their name on it or left things off of it or whatever.

JUDGE FADER: First of all she can be disciplined if she does not handle this the correct way. And secondly, the people who sell her malpractice insurance are telling her you have to check on all this stuff if you want malpractice insurance. She has no alternative but to do this to some degree depending upon her professional judgment.

MS. KATZ: We'll all be labeled with some chronic mental illness.

DR. WOLF: That's really easy to adulterate.

DR. FARAH: May I add one more factor

because you are talking about hoops. When she is going to request pain management, and in this case probably he'll need a low dose, long acting pain management. He may be on a combination of OxyContin, Percocet, or Dilaudid, for example. When she fills in the prescription she is going to attest, as requested by the insurance company, that the diagnosis is correct because they're going to ask her what the diagnosis is. And she's going to be signing, attesting, that this information is true.

JUDGE FADER: And both the federal and the state governments say that both the pharmacist and the physician have a concurrent responsibility. I see Linda mouthing this. She has only told the pharmacists this a thousand times: To assure themselves that the prescription is written and dispensed for a legitimate medical purpose. How many times have you heard that?

MS. BETHMAN: Pull the string, right?

JUDGE FADER: She has a legal responsibility for herself and to the government, in addition to

treating the patients, she has no alternative except to do this.

SPECIAL AGENT SPONHEIMER: Getting back to this program, this program will assist the physician in doing just that, in providing a thorough background check -- not check, that's a bad word. You know, providing for a background on the patient. It will show you what physicians have prescribed this medicine. You may not be aware of a physician, they may have forgotten to tell you about two years ago. And you can call that physician and get their records. In your case, not for what you are prescribing, but you gather all the information necessary to treat the patient using your best professional judgment.

In Virginia we submit our request via the Internet, secure website, type in our name, password, brings up another screen, and we get to choose a bunch of stuff. I've got slides to show that stuff in just a moment.

In constructing it, when you write -- if you

are going to write a law saying this has to be done, one of the things to consider is how often do you want the pharmacist to report. Do you want them to download every Monday, twice a week, or how often. Virginia does it twice a month. So the more often that a pharmacy or dispenser submits information, the more accurate, the more timely a report anybody gets back will be.

MS. TAYLOR: May I ask a question, how much time does that take for the pharmacy to report? Is that something that is in the computer process, where they hit a button, or is there more to it that they would need to do?

SPECIAL AGENT SPONHEIMER: I don't know a whole lot about that, so I can't speak completely intelligently on that. Virginia has a manual on how the pharmacies are to report. It is through a third party. They have data in a certain format, they submit it to a contractor which is acceptable under HIPAA, and the contractor then reports to the Board of Pharmacy, all the data. For chain pharmacies, CVS,

Safeway, it is done by central office. The individual pharmacist doesn't do anything. He types in the computer. They get the data from there, the central office, and they report it to a third-party contractor. Independent pharmacies can report it electronically, have their software contractor do an upgrade, or part of their maintenance contract, keep it in line with the technology required.

DR. LYLES: These are traditional contractors that maintain pharmacy databases like Rx Hub and places like that?

SPECIAL AGENT SPONHEIMER: Pharmacy software, whoever would do that. Or if they report on paper they can send a CD to the Board of Pharmacy, as long as it is in the proper format.

DR. WOLF: Are you going to get into the mechanics of it? In other words, do the patients need to show an ID to pick up a prescription?

SPECIAL AGENT SPONHEIMER: I'll get in to that in a minute. Yes, sir?

MR. KOZLOWSKI: In Maryland we have data

exchanges which the Commission licenses. And I suggested to the judge at some point if Dr. David Sharp, who is the -- in essence issues the licenses for this, presents so you have a sense of how data moves in Maryland because the difference between the Commonwealth and Maryland is we are unique in this country with the largest encounter database for physicians services, pharmacy, hospital, et cetera. It has been very progressive in the context of having that data source which permits us to do the kinds of reporting that we do on utilization of health care services, et cetera, through the different delivery systems.

SPECIAL AGENT SPONHEIMER: Virginia's monitoring program collects data on Schedule II, III and IV drugs. Anything listed in these schedules is required to be reported to the Board of Pharmacy. It is used by limited authorized users to assist in providing patient care and stemming the diversion of controlled substances. The information is maintained by our Department of Health Professions, Board of

Pharmacy. Obviously strict security and confidential measures are insured. Only those persons authorized in the Code can access it, no one else. We'll go into who Virginia allows access to.

Prescribers and dispensers may query to determine if a new patient is doctor shopping, especially if it is: Doc, I have back pain. Can you bend over? Sure, no problem, what do you want? Percocet. No, get out of here. You run the program and they've seen twenty physicians in the past month. It will assist the physician in making the intelligent determination that they are probably not a legitimate pain patient and handle it accordingly.

Also provides a level of risk management for the patient. I typed that wrong, didn't I? It provides the practitioner with the information needed to make decisions about prescribing, based on their training and experience.

Virginia's reporting requirements: Pharmacies, any pharmacy licensed by the Commonwealth, within the Commonwealth, is required to report to the

Board of Pharmacy. On nonresident pharmacies, Medco, Express Scripts, anything like that, are required to report anything dispensed to a Virginia resident.

Physicians holding permits to sell controlled substances are required to report.

DR. LYLES: That's regardless of whether they're from Maryland, Massachusetts, doesn't matter?

SPECIAL AGENT SPONHEIMER: That's correct. My son is on a mail order and I think they mail to Pennsylvania, and they're required to report that, dispensing that medication, to the Virginia Board of Pharmacy.

JUDGE FADER: And the Board of Pharmacy of Maryland, I don't want to steal your thunder, but requires that to occur, will require, as a condition to issue them a nonresident pharmacy license, right?

MS. TAYLOR: That's correct.

SPECIAL AGENT SPONHEIMER: That's how Virginia Code does it. If you want a nonresident pharmacy permit, you must submit. I'm sure no mail order is going to risk losing that.

DR. WOLF: You are saying the mail order that's mailing to Pennsylvania, they are filling it in Virginia, or because your insurance is through Virginia --

JUDGE FADER: If the patient is in Virginia.

SPECIAL AGENT SPONHEIMER: I mail the Express Scripts order form to Express Scripts wherever it is. They mail the prescription back to me. I pick it up and give it to my son. They're required to report the dispensing of that medication to the Virginia Board of Pharmacy, even though they are outside of Virginia.

DR. WOLF: You said the Express Scripts is mailing it to Pennsylvania.

SPECIAL AGENT SPONHEIMER: No, I'm sorry. If I'm mailing it to Pennsylvania.

JUDGE FADER: In other words, it's the person who is in Virginia.

DR. WOLF: The Virginia resident.

JUDGE FADER: If any organization for a nonresident pharmacy is filling a prescription that

they are sending to Virginia, they are required to report this to Virginia. And they can't practice and send through the mail in Virginia unless they comply with the terms of the nonresidency pharmacy provision.

DR. FARAH: May I ask a question for clarification? You are insured in Virginia?

SPECIAL AGENT SPONHEIMER: Yes.

DR. FARAH: But if your son is in school at Massachusetts, and the prescription is sent to Massachusetts because that's where your son is, but he is on your insurance in Virginia, would Virginia still get the information, even though the prescription is sent through Medco to Massachusetts?

SPECIAL AGENT SPONHEIMER: That's an excellent question.

DR. FARAH: I want to make sure how you get into that.

SPECIAL AGENT SPONHEIMER: I don't know.

JUDGE FADER: Ann, isn't it the situation with the comity clauses, that it is only the place that fills the prescription?

MS. TAYLOR: It is only the place.

JUDGE FADER: Virginia? In other words, if it is sent to Massachusetts, the drug, Virginia has filled the prescription, it is Virginia that must report.

MS. TAYLOR: I think what I'm hearing is that the parent who is the guardian is in Virginia, but the prescription is coming from a nonresident pharmacy and going to a patient that is not in the state.

JUDGE FADER: Going to a patient in Massachusetts.

DR. WOLF: From a pharmacy in Pennsylvania.

JUDGE FADER: But it is the pharmacy that fills it that must comply to report to the State, correct?

MS. TAYLOR: Yes.

SPECIAL AGENT SPONHEIMER: I don't know, it would depend on how the law is written. It would be reported to someone if that State had a monitoring program, if it is Virginia or the State to which it

was mailed.

JUDGE FADER: The DEA has some input.

MS. ROCHEE: Only because I do exactly that, I have my daughter's prescription shipped to Louisiana. She is a student. That's just the shipping address, and Medco makes a distinction between our address where we live because we're the patient. But they are just shipping it to her because that's where her temporary domicile it.

SPECIAL AGENT SPONHEIMER: Likely it would be reported to the home State. If I lived in Virginia to answer your question, under that exact scenario it would be reported to the Virginia Board of Pharmacy.

JUDGE FADER: Well, our two pharmacy people here will have to consider whether they can do both.

DR. FARAH: Just a wish list of things that we need, the housekeeping.

MS. BETHMAN: That's not clear.

DR. FARAH: It would be critical for us to address all of these things so we actually remember these later.

SPECIAL AGENT SPONHEIMER: The deadlines for prescribing -- prescriptions dispensed for the 1st to the 15th, for pharmacy and nonresident pharmacy, must report by the 25th of each month, the 16th to the last day, the 10th day of the next month. One drawback of that is the reports that you get from the Board of Pharmacy could be up to two and a half weeks behind with data, depending on if a patient filled the prescription on the 1st and you requested the prescription on the 24th, that prescription filled on the 1st is not going to be in the database because it hasn't been required to be reported yet. Pharmacies can report more often, but they're not required to. They are only required the 25th and the 10th, however they can report it as often as they want.

JUDGE FADER: Why do I have a feeling that this late reporting is due to testimony before the Virginia Legislature having to do with the inherent difficulties of the software of the pharmacies.

SPECIAL AGENT SPONHEIMER: I wouldn't doubt it, but I don't know exactly why that's written in the

Code.

JUDGE FADER: Well, I hear that all the time, but that means that that may be okay today because they have to do it, but that doesn't mean the 15th twenty years from now it will not be done instantly with a better system.

SPECIAL AGENT SPONHEIMER: I am no software engineer by any stretch of the imagination. As it gets better, the law can be amended to more accurately reflect what the government wants.

We all know what this is. These are just some examples of Schedule II, III and IV drugs that are required to be reported. There are limited number of exemptions in the Virginia Code for reporting requirements. You do not have to report the dispensing of manufacturer samples. If you dispense a sample of Ambien to a patient, it's not required to be reported. Dispensing of covered substances in an emergency, the Code really doesn't go into what is detained as an emergency for this exemption.

DR. WOLF: I suspect that this was emergency

room generated, where there is a patient in the emergency room and they actually have the patient swallow the administered drug orally.

SPECIAL AGENT SPONHEIMER: That, or if you are a physician and somebody is in so much pain from kidney stones and you determine that they need a shot of morphine, you can shoot them up, that's fine, that's not required to be reported because that's through the practice.

Dispensing of a covered substance in a narcotic treatment program. Methadone clinics are not required to be reported to the Board. Inpatient nursing homes and hospitals are not required to be reported.

DR. LYLES: Would that apply to your Suboxone treatment programs?

SPECIAL AGENT SPONHEIMER: If you as a physician write a prescription for Suboxone and they fill it at a pharmacy, it is required to be reported. However, I don't know how that would work -- as an in-office dispensing, if you dispensed it in-office,

it would not required to be reported.

DR. LYLES: It works both ways actually.

SPECIAL AGENT SPONHEIMER: I don't know exactly how that -- but if you write the prescription and they fill it at CVS, it has to be reported. But if you dispense it in your office --

DR. FARAH: You have to keep a log. If you dispense it in your office, you have to keep a log saying when you acquired the medication, lot number, expiration date, when you gave, how much, and to whom. I keep that log in my office for inspection by anybody anytime that is required. That is standard procedure. That's what we have to do. That's what the regulations say.

SPECIAL AGENT SPONHEIMER: That information would not have to be reported. The physician would not have to report that, unless he is licensed to dispense or sell. In Virginia there are a lot of rural areas, in the Code, where a physicians can apply for a license to act as a pharmacy pretty much.

JUDGE FADER: You can in Maryland, also.

SPECIAL AGENT SPONHEIMER: So if a physician is in a very rural area and they write a prescription for ten Percocet for a patient, and they dispense ten Percocet to the patient, if they are licensed to do that, that must be reported. And hospice dispensing is not required to be reported either.

Virginia's laws and regulations.

JUDGE FADER: When you say they are not required to be reported, you mean as part of this program?

SPECIAL AGENT SPONHEIMER: That's correct.

JUDGE FADER: Because as the DEA and the Maryland Board of Pharmacy will tell you, they all have requirements in drug control, Georgette, that they must keep these lists and if everything is dispensed in an emergency room, et cetera. It is just not reported as part of this program?

SPECIAL AGENT SPONHEIMER: When I say reported, I do mean to the Board of Pharmacy to be included in the Prescription Monitoring Program. Sorry. Thank you for that distinction.

This Code section just requires the director of the Department of Health Professions to establish the Prescription Monitoring Program and determine what schedules will be reported. They have to provide a basic file layout to the pharmacies to which report their information. And that section provides just for mandatory reporting requirements from the pharmacy. Failure to report on the pharmacy's part is to have action by the Board of Pharmacy. There is no criminal penalties in Virginia for failing to report for a pharmacy or pharmacist for failing to report.

MS. KATZ: One quick question. Was there a lot of conversation about where to house this database? Because one of the issues that I know often comes up is whether or not it can be in the department of health as you have it, or whether it should somehow be in the law enforcement area. And quite frankly from our standpoint, from the standpoint of the patient, it is much better that it be in the Department of Health. So I congratulate you on that. Do you know whether or not that was a lengthy

conversation, or was it kind of a given?

SPECIAL AGENT SPONHEIMER: From the reports I've read about the implementation of the Virginia program there was never any discussion. It was the Department of Health Professions should, in my opinion, should have it, law enforcement should not be required to keep it. Because the number one purpose of the program is to assist patients with treatment, not to catch violators. Because if it is under law enforcement there may be that error or suspicion that they're monitoring us.

JUDGE FADER: Perhaps we can put in an earmark there and ask the State Police somewhere down the road whether they would be in a position to tell us whether they care about that. Not now, but perhaps down the road.

SPECIAL AGENT SPONHEIMER: Pharmacies have to report the following information: Patient's name and address, date of birth, what was dispensed, quantity, date, prescriber's identifying number, and dispenser's identifying number. Nothing more that

wouldn't be on the back of a prescription -- on the sticker that's affixed to the back of the prescription once it is filled. Data is confidential and exempt from the Virginia Freedom of Information Act. No one can get it. Can't send a letter to the Board of Pharmacy saying, I want my neighbor's prescription monitoring history. Can't do that. It is exempt. It is also subject to the protections of HIPAA. Virginia Code provides for two types of disclosure by the director of the health professions, mandatory and discretionary, the two different types that the director has the authority. They must disclose information relevant to a specific investigation, specific recipient, dispenser or prescriber to an agent designated by the superintendent and the State police to conduct investigations. There are only eighteen law enforcement in the State who can directly query the system, and that's it, only eighteen. Local law enforcement officers are not granted access. So people that are employed by sheriff's offices, county police departments, city or town police departments

are not granted access to this information. They cannot log in, they cannot get an ID or a password. Only eighteen law enforcement agents in Virginia can do that.

MR. MOONEY: Excuse me. Do they request the information through you?

SPECIAL AGENT SPONHEIMER: They can. I'll get into when we can do a secondary dissemination in one minute.

Information relevant to an investigation or inspection of alleged misconduct to an agent of the Board, any regulatory Board. Virginia has the Department of Health Professions and they have investigators that work for all Boards. One investigator may have a case before the Board of Pharmacy, Board of Nursing. They can query this system as well to assist in their investigation. That's a required dissemination.

MS. KATZ: That's in addition to the eighteen?

SPECIAL AGENT SPONHEIMER: Yes. These are

people who it is mandatory.

Information relevant to a disciplinary hearing before a health regulatory board or an appeal. They can disclose it to an agent, or to the board itself. You as a member of a board of medicine can request a report on a physician. Depending on what the investigation entails, you are entitled to that information for the disciplinary or civil regulatory hearing.

JUDGE FADER: That would be also providing they have opened up a case for investigation.

SPECIAL AGENT SPONHEIMER: Absolutely. And to designate a person operating in a health practitioner's intervention program. Virginia has an HPIP for practitioners who are impaired or who have substance abuse problems, a first-line program to get them back on their feet, get them well, back into practice. And they can do that.

Information relevant to proceedings of any grand jury or special grand jury, and information relevant to a specific investigation, the dispenser or

prescriber to an agent of the Drug Enforcement Administration. Notice it doesn't say patient information to the Drug Enforcement Administration. In keeping with the DEA's mission the diversion investigators are more on the regulatory side of things, so they would have information accessible to licensees: practitioners, pharmacies, people that they license. They don't license patients, so they can't access patient information.

MR. CLARK: Tim Clark with the Maryland Chiefs of Police. You said earlier that out-of-state agencies could get access to the system. Does that include out-of-state law enforcement people?

SPECIAL AGENT SPONHEIMER: No. The only law enforcement that have access to this are the eighteen diversion agents. But out-of-state physicians and dispensers can access the system.

MR. CLARK: So an out-of-state law enforcement agency who had an interest in something they would come to you and explain why they were looking for this, that they had an investigation, and

then you would then have to open an investigation on your end to be able to access it?

SPECIAL AGENT SPONHEIMER: For a possible crime committed in Virginia, absolutely. And I can disseminate it for a joint investigation. I can disseminate to the people with whom I'm working in an investigation, absolutely.

The discretionary disclosure: A patient can request their own report. Usually 99 times out of a hundred, they're going to get it. Under the Code the director does not have to give it to them.

DR. COHEN: Is it defined on the description why they may not want to? I find it curious it is discretionary.

SPECIAL AGENT SPONHEIMER: I have no idea.

JUDGE FADER: We have a lot of stuff in Maryland if there is an ongoing investigation and things of that sort. We can look into that and give you an answer to that. But a lot of police reports are not available to a person of interest or something of that sort, and it is particularly stated in the

Maryland Code. We'll look in Virginia and see what the situation is and give you a comparison of Virginia to Maryland. In other words, the State Police are conducting an investigation. They sure don't want you knowing what they're doing until they're finished that investigation. But the specifics I'll compare and give back to you.

SPECIAL AGENT SPONHEIMER: Information relevant to a recipient to a prescriber. If you as a prescriber query the system, you are going to get a return. You are going to get the information. There is no way that the director is going to say, uh-uh, I'm not going to give you that as a physician, or a nurse practitioner, or prescriber. They're not going to say no to you. But it is written in the Code it is discretionary. Why? General Assembly does some strange things.

Information on a specific recipient to a dispenser. They can under -- when it was first piloted pharmacists did not have access to the information. They couldn't query it. It was only

diversion agents and prescribers. They changed it. One of the recommendations was give dispensers access, and they did. Again, that's under the discretionary, but you are going to get it. Pharmacists are going to get it. Can release it to the Medicaid Fraud Control Unit of the Attorney General's Office. And information relevant to death investigations conducted by the Chief Medical Examiner or the medical examiner for the district in which the death occurred.

JUDGE FADER: I would ask you to look for a convenient place to stop for a ten-minute break.

SPECIAL AGENT SPONHEIMER: Let's stop here. This is fine.

JUDGE FADER: That will be fine. Ten minutes. See, they take fifteen, so I say ten.

(Brief recess.)

JUDGE FADER: We need to resume again. We're trying to get out at twelve, 12:30 every day so that you can go make a living, and treat patients, and arrest people. Thank you.

SPECIAL AGENT SPONHEIMER: We stopped in the

part of the Laws and Regulations. This is the Virginia Code, probably unique to Virginia, that allows any agent designated by the superintendent to conduct diversion investigations, or Board agents, agents of the Department of Health Professions to reasonable hours inspect and to have access to all such records relevant to that specific investigation.

Pretty much if I'm investigating a patient that you saw once or twice, and I come to you and I say, Doctor, I'm investigating this patient, I'm Agent Sponheimer with the State Police authorized to conduct drug diversion investigations, I want the patient records. This is the Code section that covers you for giving it to me.

DR. WOLF: Without a warrant?

SPECIAL AGENT SPONHEIMER: That's correct. Without a warrant, court order, or subpoena. This is the Code section that covers you to give that to me. My layman's interpretation of why the General Assembly put this in there is so it does not create an undue burden on diversion investigators because that's all

we do. If we had to get an order every time that we wanted to get patient records, the judge would get mad at us. All they'd see is us. Search warrants are time consuming, subpoenas. In order to streamline everything and also to protect patients, they put a law that says only us. If a regular agent came in or a police officer in uniform and said, I want these. No. Judicial process.

DR. WOLF: How do I know the difference?

SPECIAL AGENT SPONHEIMER: We have a little special card that says I am authorized to conduct drug diversion investigations.

DR. WOLF: It is not photocopied?

SPECIAL AGENT SPONHEIMER: It is blue, and if it is photocopied it is black.

DR. FARAH: I'm sorry. What information can you get?

SPECIAL AGENT SPONHEIMER: Patient records.

DR. FARAH: Actual patient records?

SPECIAL AGENT SPONHEIMER: Photocopies of the records.

DR. FARAH: Of medical records on patients?

SPECIAL AGENT SPONHEIMER: Yes. If we have an investigation on that patient, and we're one of the eighteen agents of the State.

DR. WOLF: Including psychological records?

SPECIAL AGENT SPONHEIMER: Information relevant to the investigation. So if they come in and say, kidney pain, and you give Percocet because you think they could have kidney stones or they have blood in the urine that would indicate kidney stones, specifically relevant to that. Or if they're doctor shopping for Adderall or whatever the case may be. If they say, can't concentrate on anything and do that, and you prescribe Adderall for that, then we see that.

DR. GANDHI: This is done without a subpoena?

SPECIAL AGENT SPONHEIMER: Yes. And also this same Code section provides for if we during the course of our investigation come up with anything that may be a violation of a Board regulation we are required to report it to the Board.

DR. WOLF: What does that mean?

SPECIAL AGENT SPONHEIMER: If we are in your office and we notice that -- I don't know the Board regulations so I don't report it that much. But if something seems fishy, or if I go to you and say this patient is doctor shopping for OxyContin. And I show you the list and I say he has gotten in the last month four prescriptions a week for 90 count Oxy 80, and he comes to you next week and you prescribe for him again, while really not a violation of the criminal law because he does have a justifiable medical need for that, it would probably be reported to the Board, and the Board would take whatever action they deem appropriate.

DR. FARAH: We look at it as a standard of care issue. You look at a case. I don't see that as a problem, but I do already see as a problem is the access to the medical records. I see this as a huge problem, particularly in Maryland because every year we have cases that are being presented, in legislative efforts, are being presented in that capacity, this

whole issue of patient confidentiality.

SPECIAL AGENT SPONHEIMER: This is not part of the Prescription Monitoring Program legislation at all. I'm just giving you the background of how the diversion investigators of the State Police operate and under what authority we operate.

MR. KOZLOWSKI: Let me ask you a question. How many cases have occurred over the last ten years which you have been sued, chastised, or deflocked for inappropriate use of patient records? Is it somewhere around zero?

SPECIAL AGENT SPONHEIMER: Me personally, no.

MR. KOZLOWSKI: No. The eighteen.

SPECIAL AGENT SPONHEIMER: I can't answer that because I don't know about the other seventeen, but me personally, none. If I get a record, I keep it in a manila envelope, put it with the case file, and it's locked. I don't keep it on my desk or keep a copy of it with me. It is just used to determine probable cause for an arrest, or it's --

MR. KOZLOWSKI: Would you be willing to query Virginia State Police and give us back information as to whether there has been any difficulty as a result of inappropriate access to patient records?

SPECIAL AGENT SPONHEIMER: Sure. I can contact our legal specialist and e-mail Ms. Forrest.

JUDGE FADER: I believe you told me when we talked about this is that you really know of none or have heard of none.

SPECIAL AGENT SPONHEIMER: That's correct.

MR. WAJDA: Do you shred those records after a certain amount of time?

SPECIAL AGENT SPONHEIMER: Absolutely. After the case is closed the case information is sent down to our headquarters in Richmond to be microfilmed. However, the patient records are not, they're shredded. This is the same Code section that says any agent of the Board who in the course of their investigation finds a violation of the Drug Control Act of Virginia must report it to the State Police.

That's all.

This has to do with the confidentiality of the records. We cannot release it or divulge it, except in connection with the criminal investigation or when it is authorized by the Attorney General or the Attorney for the Commonwealth.

Reading the whole section minus the little dots I take that to mean that's the secondary dissemination to a local police officer. If a sheriff's deputy comes to me and says, I'm working a prescription fraud case where the patient is seen on videotape passing fraudulent prescriptions, has been picked out of a lineup, and here are the fake scripts, can you run a Prescription Monitoring Program report and see what else, if there have been any, so I can obtain them all in my County and charge appropriately where there is a basis for a fraud. Absolutely. But the Attorney General's Office or the County Attorney or Assistant County Attorney has to approve that dissemination of that report before I even run it. In the case number field I would use their case number.

But they have to prove it, and I have to keep a log of that dissemination, secondary dissemination to them. Just what I said.

Any unlawful disclosure of the information that I have in my possession is a Class I misdemeanor, which in Virginia is up to a year in jail and a $2500 fine. So if I do something I'm not supposed to with the information, at least without authority, release it to the wrong person, I can be charged.

DR. FARAH: What is the statute of limitations for discovery?

JUDGE FADER: One year in Maryland. I don't know what it is in Virginia.

SPECIAL AGENT SPONHEIMER: A year in Virginia, as well.

DR. FARAH: That's why I bring it up.

DR. WOLF: Hold on one second. Does that apply from one provider to another as well?

SPECIAL AGENT SPONHEIMER: This is any person having access to confidential information in possession of the program, meaning the Prescription

Monitoring Program.

DR. WOLF: I'm a specialist. The patient who comes to see me is a patient of the primary care provider. Can I disclose this information to the primarily care provider?

SPECIAL AGENT SPONHEIMER: From the Prescription Monitoring Program? The primary care would have to run their own report, and that would be perfectly acceptable. I think if you did that you may be violating it by the letter of the law, but the spirit, no.

JUDGE FADER: We may be able to do something with that because there are exceptions in the Maryland Medical Records Program, which is actually a stiffer responsibility than HIPAA. And they allow that transfer between physicians, providing there is a legitimate medical purpose, which takes twenty seconds for the physician to tell you, Marcie, here's what I need, here's why I need it.

SPECIAL AGENT SPONHEIMER: The other physician can just run their own report.

DR. WOLF: But it is not as practical for them to do it as it is for us to do it.

SPECIAL AGENT SPONHEIMER: Meaning run their own report?

DR. WOLF: Yes.

SPECIAL AGENT SPONHEIMER: It would take the same amount of time it would you, as it took you to run the report, it would take them the same time. But if it is in an emergency situation, hey, what does he need, I think you would be okay to release it to him.

DR. FARAH: Then in an emergency it is usually two weeks after the request was done.

SPECIAL AGENT SPONHEIMER: Did I answer the question?

DR. WOLF: You did answer my question. I think that your assumption that the primary care provider would either have the capability, or the staff, or the inclination to do it is probably a bit misguided, but --

SPECIAL AGENT SPONHEIMER: Everybody has access to the program.

DR. WOLF: I understand.

SPECIAL AGENT SPONHEIMER: The inclination, that's a different story, exactly.

DR. MARTIN-DAVIS: Are you saying the primary care has to ask the specialist for the information?

DR. WOLF: No. Directly access it themselves.

SPECIAL AGENT SPONHEIMER: Under the Federal Criminal History Guidelines, if I run a criminal history on somebody and another trooper ran a criminal history, he would have to run his own copy. You have to obtain your own copy to log the dissemination of who gets the information. It is just to keep a record of who gets the information and who obtains a copy.

DR. WOLF: Because if I obtain that information now by other means, it's disclosable. If I get it from CVS, Rite-Aid, and all those put together, I'm not beholden to them.

SPECIAL AGENT SPONHEIMER: Exactly.

DR. MARTIN-DAVIS: I was going to say, just

so I'm clear, I guess in the reverse, if I have a patient and I know he is doctor shopping, and I get -- I know he is doctor shopping, but I go online and I get the information and I have it in my chart. You know what, I can't treat you anymore, I'm discharging you. He goes to her. She calls me and says, hey, I have some of your medical records, I have a patient all the way up here and he is coming to see me and he previously saw you, what is the deal, why did you discharge? Are you saying I can tell her this information, or I can say, well, maybe you should run a report on him and see, or can I just tell her without her asking me?

SPECIAL AGENT SPONHEIMER: You can disclose whatever you normally disclose, just not a copy of the report. You can say they've seen five doctors in the past week, gotten five prescriptions for narcotics.

JUDGE FADER: That's part of your medical record thing, so you can disclose that.

DR. MARTIN-DAVIS: Why couldn't I give it to her?

JUDGE FADER: Well, that's something we have to talk about. Virginia says no. That doesn't necessarily mean the Legislature in Maryland will say no. It is something we need to talk about.

MR. WAJDA: This looks like disclosure to third parties that are individuals or persons not in the flow of patient care. If you go to your next slide, you talk about persons that are authorized. Maybe that would shed more light on this. It seems reasonable for specialists to get information from the family practitioner.

DR. FARAH: It doesn't happen. If you are under the care of a psychiatrist and I ask for medical records, and I get something to Dr. Farah, my letters from psychiatrists are stamped confidential. I have no right to make a copy of whatever I received from the psychiatrist.

MR. WAJDA: To someone else?

DR. FARAH: To her. To help manage the patient, I can send her my chart, my records, but if I have copies in my chart of information I got from a

psychiatrist on the same patient, I cannot copy them and send them to her.

JUDGE FADER: Not without the consent of the patient because psychiatric records are very strongly treated as different under Maryland State law.

DR. FARAH: Right.

DR. LYLES: The commercial EMRs now don't permit you to print. Say I get the same information that you are giving me except for the sell case, but they don't permit you to print. With your system I get a printed copy?

SPECIAL AGENT SPONHEIMER: Of the prescription report?

DR. LYLES: Yes. And that's what I can't transfer to another physician?

SPECIAL AGENT SPONHEIMER: According to that, yes, but I'll go into how other reports get to you and how they get to be printed, absolutely.

Accessing the data -- I think this will answer your question, but if it doesn't please ask me again. Reports are requested through a secure website

operated by the Virginia Department of Health Professions. The requestor submits the patient's name, date of birth, address, and the date range for which they want data. And in the law enforcement case they have to submit a case number. This just goes over, again, must submit case number. You can also fax a request or send it through the mail if you have time.

Access to the reports once they're ready, access them through the same website. No big deal. They're returned in .pdf format so they're not changeable, but if I have an investigation where I need to manipulate that or there is a large amount of data, I can request it in Excel format.

JUDGE FADER: And Adobe is selling software now that does make .pdf changeable.

DR. WOLF: You can lock a word file, too.

SPECIAL AGENT SPONHEIMER: This is a picture of the website, my user name and password. And that pops up. And on the upper left-hand side you will see requests. If you click on that, it will say view,

submit. Just like that.

This is one where I'm submitting it on a patient or I wanted to submit it on a patient. I have to put their last name, first name. I don't need their social, don't need their age. I need the date of birth. If an exact date of birth is not known, you can do a date range and it can probably pick it out of the system, and an address verification. If they have an alias, I can also search by an alias. If we know their name is Judy Smith, but they're using Jane Smith, I can search that as well for the purpose of fake prescriptions. Date range, you have to certify that the information you enter is accurate. And for law enforcement, you have to put a case identifier at the very bottom.

DR. FARAH: It says here twelve months. How long would you keep the data?

SPECIAL AGENT SPONHEIMER: That's default. Twelve months is the default range. This went statewide on June 1st of '06. I can request back to June 1st of '06 for Schedule II, III or IV drugs. I

don't know how long we're going to keep it. I would assume the server can only get so full.

This is the form for requesting information on a practitioner: Name, DEA number, and practice address, date range, and case number that I would need. This is my cross form for a pharmacy. If I knew a pharmacy was dirty, or they're off the chart with dispensing hydrocodone or something like that, I can request that if I have an open criminal case.

When I view the report, that's what I get back. Names are blacked out just in case anyone else gets a hold of the handout or anything, they don't need to know. What type of response and what type of -- whether it was a patient, practitioner, or pharmacy, and the date and time I submitted it. When you click on the name, it will bring up this form and it will say patient utilization report, .pdf. Click on that, open the .pdf up and there is the file, there is your report.

That's a copy of the Virginia Prescription Monitoring Program report. This was run on a patient

who was passing fake Adderall scripts. It has the pharmacy name and number, date that it was filled, prescription number, quantity, days of supply, drug and strength. It was all input by the pharmacy.

One thing I will tell you about this report, though, there is an error on this. These prescriptions were actually written and filled for Adderall XR 30 milligrams, not the 7.5 and 6.25. I don't know how that happened, but it is a glitch. Goes to show that this information on this report is not always one hundred percent correct. There can be errors. It needs to be verified with the pharmacy. When I went to these pharmacies, they said, no, it was Adderall XR 30 milligrams. How in the world did it get reported as Adderall Extended Release 7.5, I have no idea.

MR. CLARK: When it was inputted they didn't input it wrong?

SPECIAL AGENT SPONHEIMER: I don't know. It was in their computer as proper, what was on the drug. So I have no idea.

DR. GANDHI: Can patients request corrections in their record?

SPECIAL AGENT SPONHEIMER: I don't know. I don't know of any mechanism for that.

DR. GANDHI: Because if somebody has a long list like this and there are errors in that, that person could be stigmatized for a long time.

SPECIAL AGENT SPONHEIMER: You are exactly right. I don't know of any method where a patient can ask that.

JUDGE FADER: What he is referring to is Maryland does have in their confidential record program an area that the patient can request a change. However, the pharmacist and the physician are not able to change the record, they are only able to state patient requested this change because of such and such.

DR. WOLF: Is that true for the practitioner as well? Because we see it all the time. If the primary care writes for their blood pressure medicine and then they automatically default to that doctor for

every prescription that comes in.

JUDGE FADER: The law says that you cannot change the record completely. It just says you can note the change that the patient wants. If the patients want to take it to court and the judge signs an order, done. But nobody wants to do that. Nobody has the money, except Linda Bethman.

SPECIAL AGENT SPONHEIMER: Yes, ma'am. Did I answer the question?

DR. WOLF: It was probably directed to the judge. The point being it is only as good as the data that gets put in and the data that gets transferred from one system to the other.

SPECIAL AGENT SPONHEIMER: Absolutely. Just like anything. Do you have a question, sir?

DR. COHEN: No.

SPECIAL AGENT SPONHEIMER: How we use the reports, under Virginia, this may be more Board policy than law, a prescriber, practitioner, or dispenser can discuss your report indirectly with the patient, other health care providers, and the dispenser who is going

to dispense medication to the patient, not give an actual copy of the report to anyone, including the patient. They can request their own. It goes back to the transfer. If you want a copy of it and you are inclined to do it like some may not be, then they don't get a copy of under the Virginia system. Like I said, the one good thing about making your own, you can make it any way you want.

MS. HERMAN: What about family members if or anybody is over eighteen?

SPECIAL AGENT SPONHEIMER: Then they have to request their own. If your child was 19 and you wanted a copy, they have to request their own because they're of legal age.

JUDGE FADER: There is also Maryland law which talks about treatment programs and things of that sort where younger patients, I think some as young as 14, you two would probably know better than me, can keep the information from their parents. But that's all with specific legislative enactments.

DR. FARAH: That's for pregnancy.

JUDGE FADER: HIV, things of this sort, different infections, but that's all set forth in the Code, specific sections and age statements, but I think one of them is as low as 14. I can't remember.

SPECIAL AGENT SPONHEIMER: How we use reports. Again state police diversion agents request on prescribers, dispensers, or patients with an active criminal investigation. Also no case can be opened if a complaint is generated by law enforcement's review of a PMP not already subject to an investigation.

So if I have a patient or you have a patient where they're using 30 different names, but they're using one DEA number, they're using your name and your DEA number, but 30 different patient names, 29 of which are not known, what I will do is run a report on your name and DEA number. It is relevant to a specific investigation, not of you, but of that patient, of the group using your name and DEA number fraudulently and forging your signature. However, if during that I say what is this doctor thinking, why are they prescribing, I'm generating a case, I can't

open a case on that unless I have a complainant and I can't be the complainant because I don't know how many of those other ones that are off the chart are fraudulent. I would call you and verify patient's name. Do you have a patient by this name? Yes. No, that is not a patient. That would be acceptable cooperation.

MR. CLARK: Could that prescriber then say I want you to investigate this, and then you have a complaint?

SPECIAL AGENT SPONHEIMER: What I was talking about is investigating a prescriber. I'm like, man, they're off the chart. I can't investigate them without a complaint. But I would call the prescriber and say, especially if you tell me, I don't write for OxyContin, I've never written for OxyContin. All the OxyContin prescriptions are fake, well, that's easy. But if there is a 200 Dilaudid prescription there, and I call you and say is this a patient, yes, it is. End of story. I wouldn't ask why you write 200. That's a medical judgment. It is

not law enforcement at all.

Information with the Court is always verified with the practitioner or dispenser before enforcement action is taken. That's why I verify the actual scripts were written for Adderall 30. Ninety-nine percent of the scripts you saw on that report for Adderall were fake, the practitioner didn't write them. They were just filled under the patient's name.

Treat data on any prescription monitoring report as that of an informant. Verify it first before you do anything. Any enforcement action, we have got to verify the information.

DR. WOLF: When you verify the information, is that done live? Would you go in and actually look at the scripts, or would you request that the practitioner, the pharmacy or whatever, create, generate, a pile of photocopies, records, whatever, and then put the burden on them to provide the data to you?

SPECIAL AGENT SPONHEIMER: No. It would be

my burden to verify. I would either call you or call the practitioner and verify it over the phone, or call the pharmacy. I've been in enough pharmacies in Fairfax County that they know me, know who I am. The ones I don't visit frequently, I would go in and show my badge, this is who I am, this is what I want. Okay, go ahead. I wouldn't see the original copies unless they were fraudulent. I would just obtain a patient profile from the pharmacy of that patient.

It is not evidentiary in nature, not admissible in court because of the errors that are inherent in them or can be inherent and can be displayed on them.

Safeguards to taking any prescription report I get. It is attached to a case file. I will document that I ran it, write a report that I ran it, submit it with the case file just to document a course of investigative action, not to make that data part of the case. Well, why did you go to this pharmacy? Because I got this information from this report. I went here. I got this and went there. That's

acceptable.

DR. COHEN: So your evidence has to be the actual prescriptions? This just leads you to the evidence that you need to gather?

SPECIAL AGENT SPONHEIMER: Exactly. It has to be -- the evidence would be the prescriptions, the pharmacist telling me that's the person who did it in a photo lineup, video, testimony of the practitioner, I didn't write that. That would be the evidence. This is just the tool, how we use it, tool to guide us in our case.

It is for use in criminal cases only, not administrative investigations. They contact us sometimes, internal affairs, say we have this officer who we think is doctor shopping, can you run a PMP. Do you have a criminal case open? No. I can't help you, I'm sorry. You have to go get it the old-fashioned way. Even then I don't know if they can get that through administrative investigation purposes. There is the difference. I can't give it to them and I won't. It is the unlawful

dissemination, classified as a misdemeanor, and I know a judge would throw me in jail for a year.

DEA diversion investigators can request on specific patients. Excuse me. Prescribers or dispensers do not have access to patient information. Just an example, if you have time for half a war story, I guess. I received a call from a pharmacy saying, hey, we got this fake script under Dr. X's name. Okay, we went in. They found a couple more during the course of their search. I didn't know who did it, so I ran a report on the doctor's name, DEA number through the Board of Pharmacy, saw a bunch more fraudulent scripts and a bunch of them happened to be a pharmacy that collects driver's license information for C-IIs. So I was able to identify a bunch of suspects that way. But I was running the doctor's PMP, not to check out the doctor, but to check out where other fraudulent prescriptions might be to develop leads in another criminal case, not to develop a criminal case on the doctor.

There is another one. I checked another

doctor's prescription reports because we received reports of fraudulent OxyContin scripts under numerous names in Virginia. Discussed the report with the office manager and verified the patient's name. During the conversation there was one patient who was identified as filling multiple scripts for hydrocodone. I did not open a case on that patient because I did not have a complainant, an outside complainant. It was developed from the use of a PMP, I didn't feel comfortable and I didn't think it was acceptable to open a case based on that. I could, but I didn't because I wanted to err on the side of caution and not do it.

Another pharmacy. This one a pharmacy has been listed as a dispenser of numerous prescription reports that I run on people selling OxyContin, Dilaudid, methadone. I see this pharmacy pop up all the time. They usually overlap, fill overlapping days of supply, they fill a 30 day supply for one drug for one doctor, ten days later, different doctor, same drug, same quantity, same days of supply. The

pharmacy, it is one of the smaller independent pharmacy, likely is not doing his due diligence to make sure -- it is like four or five doctors, not just two. But I don't have a complainant for the case so I can't open one.

MR. CLARK: Couldn't you call DEA diversion and say you might want to take a look at these people.

SPECIAL AGENT SPONHEIMER: I may be walking that fine line of using this information to open a criminal case. Unless I got a complaint saying they're filling fake scripts, I really can't do anything, or unless a DHP calls me and says I noticed this, I can't do anything. It is not an acceptable use of the reports for law enforcement purpose.

Another doctor, doctor was suspected of distribution of OxyContin. We arrested somebody who was selling to an undercover and they said, all you got to do is walk in there, tell them what you want, you got it. There is my complainant, confidential reliable informant. Based on that, I ran a prescription report on the doctor information. That's

what I found, number of prescriptions in a month. That doesn't seem like much for a pain management physician, seems within the bounds. On its face, no problem. Then you learn that she practices Monday, Wednesday, and Friday from nine to noon, nine hours a week. That raises a little bit more. You notice in April, 2008, 696 prescriptions. That's 19 prescriptions an hour. I'm not an expert, but it seems like a lot to me, especially when you have people lined up out the door. And everybody we arrest seems to say she is the prescriber of record. That's acceptable use of the data to run the PMP on that physician.

One big concern, and it is a good concern and I'm glad that people are challenging me with the question is how is law enforcement access controlled, how can it be controlled. How are some ways we cannot have the overzealous police analyze patient data?

This is not Virginia law, this is just throwing some talking points out there for the group to discuss and consider if you want to or not. It is

your group. You can develop this program how you want it, and that's a good thing. Maybe it was stuff you thought of, stuff you haven't thought of.

Who in the law enforcement community are you going to grant access to this program? How are you going to determine? Are you going to determine it by size of the department, size of the population which they serve, arrangement of the department, specialized units for specifically doing diversion, or are you going to have any officer or investigator can have it as long as they attend a training class of some sort developed by the Board or in conjunction with law enforcement? Something to think about it. Virginia doesn't have -- anybody can transfer into the diversion unit, and once you are in there you have access to it. If you transfer out, you lose access to it. You don't keep it. They're pretty tight on that.

Another control that you all can use is establish laws that provide for criminal and/or civil sanctions for the unauthorized use or access. If you

guys are going to grant access to law enforcement, that's going to be done and it should be done. There should be penalties for unauthorized use of this information. Are you going to require special training for law enforcement officers before they're granted access? Training on, hey, if this doctor is a pain specialist and they write a patient a prescription for 120 OxyContin 80s, that's within the bounds, well within the bounds of legitimate medical practice, and just because -- when I first came on, I didn't understand, I didn't know, nobody explained to me that a physician can prescribe OxyContin and Percocet. I didn't understand so I asked a physician why is this. They're like, breakthrough pain, OxyContin might wear out after eight hours, they need something to get them to the next pill, don't want them to overdose. Okay, I completely understand.

A training class would help law enforcement if they're granted access. What is legitimate? Again, that is probably determined by a myriad of things, but what is even acceptable may not be the

right word. Normal, not normal, might want to query, why physicians prescribe certain drugs, for what purpose.

Yes, ma'am?

DR. MARTIN-DAVIS: I understand what you are saying, and clearly education is important, but previously you said that you go by the evidence and it is the physician's decision to give 200 Percocet or whatever. I guess my concern is with four, five, six pain management doctors in here, we may have all different reasons and different meds that we're comfortable with, so for us to get a roomful of law enforcement people and try to explain to you why we do what we do, you may get six different explanations. I guess at the risk of sounding rude, if you guys just do your job, it shouldn't make a difference to you why we use OxyContin and Percocet or why we use Dilaudid and Fentanyl.

SPECIAL AGENT SPONHEIMER: That should be something that is explained to them. That's exactly what officers need to hear. You know what, I'm the

doctor, I went through medical training, don't tell me what to write and don't tell me how to treat my patients. However, if I'm prescribing without a legitimate, without a valid patient-practitioner relationship, that's where we step in. If you are distributing the drugs just for $300 a script, that's where law enforcement steps in. If you are treating a patient the way you see fit, law enforcement stays out of it. Whoever you are talking to, part of the training needs to say.

DR. MARTIN-DAVIS: Okay, I get that. But I'm saying, look, this guy, I don't know, even if he doesn't have cancer, he has got a bad back. Marcia may say he only needs 20 OxyContin a month. I think he needs 60, or I think he needs 200, and I've got documentation that he has had, whatever, five surgeries. So, again, who are you to say that my 200 -- or why does 200 raise a flag when I'm saying here's my documentation of his diagnosis and illness. Just because she and I think differently on this doesn't mean I'm wrong, why are you investigating me?

SPECIAL AGENT SPONHEIMER: You are exactly right, and that's exactly what, whoever, the law enforcement officers, if you provide training as part of access, need to hear. That's exactly what they need to near and that's exactly what I needed to hear when I started.

JUDGE FADER: You also need somebody to go to if you have a question, an experienced medical practicer, that there are differences of opinion.

DR. FARAH: Thank you. That's my biggest concern from the get-go. My concern is the apprehension that's going to be out there that somebody is out on a witch hunt or somebody is going to disrupt my practice with an investigation without a body sorting through, is this legitimate or is not legitimate.

SPECIAL AGENT SPONHEIMER: Legitimate versus non-legitimate is a medical call. As part of the training program, if that's what is decided, that's what needs to be heard as, hey, there are differences of opinion in the medical community for the same

condition.

MS. FORREST: The purpose of the law enforcement getting involved is based on the fact that you have suspicions that there is something illegal going on. It is not a differing of how many pills you prescribe as opposed to what she prescribes. It is based on what you're suspicious of, this patient is doctor shopping because you think this, this, and this. That's what the guidelines I would foresee being to the police officers. When I'm looking at a patient that comes in to me, I'm going to determine, like you said, that patient came in and they have bone cancer. And all the stuff you looked into to make sure that they were correct, because they weren't emaciated or anything like that. The guidelines are going to be what do you believe are the suspicions for me to have a law enforcement agency to come in and look into this particular person or this particular doctor.

DR. MARTIN-DAVIS: But those are going to vary.

JUDGE FADER: They sure are.

MS. FORREST: They are, but there will be certain specific ones.

JUDGE FADER: It is like a medical malpractice practice case. I have these two for the plaintiff saying the defendant committed malpractice. They have more initials after their name. And then I've got these two coming in testifying for the defendant that these two don't know what they're doing. So it is nothing that we cannot deal with in the system. It happens in medical malpractice, dental malpractice, engineering malpractice cases every day.

But what the point is, is there has to be built into the system the wise physician that you can go to that says, this isn't a drug abuse, this is just a difference of opinion. And even though I think so and so is wrong, there are things out there. That's all they're saying.

SPECIAL AGENT SPONHEIMER: Absolutely. And you are exactly right to be concerned because there is that potential for that abuse. And part of whatever,

if you decide to put training as part of the program, agents or officers that have access need that to be explained, there are differences of opinions. Thank you for bringing that up. I appreciate the opportunity to respond to that.

MR. WAJDA: I think the 2006 bill had a medical evaluation panel included in it, which is probably a good thing to guide law enforcement.

DR. FARAH: That's absolutely a must.

DR. LYLES: We still have the lay idea, and I want to use the layman word of overprescribing. This is kind of prevalent throughout the community. And we can't define overprescribing. Now, I noticed in the Virginia Board reports it is inappropriate prescribing. It has been changed from overprescribing. We still have these soft terms, and law enforcement likes to latch onto these soft terms because it is easy to do.

JUDGE FADER: They can't do that because it is the same thing with internal medicine. Somebody comes in to an internist and they are taking all this

medication. And then they go to another internist, and the other internist says, this is nuts. They take them off of everything there, they put him on this and this. And that doesn't mean one of them is wrong and one of them is right. It is just a different perspective. It is not only with regard to this. It is with regard to the practice of medicine.

So that medical evaluation board, I'll get that 2006 bill and I'll get it from the file and we'll circulate it.

MS. KATZ: I think what you are saying, which is great, is that law enforcement people generally don't have much of a sensitivity to the scope of legitimate use of these medications. And it is very easy for them to say 200 pills, who needs 200 pills, period, doesn't matter what the dose, just to look at it very, very simplistically. And to include in the training all of the strictures that you talked about, about legitimate use, and access, and all of that clearly has to be there, but I think it is important and that is something we can clearly adopt.

SPECIAL AGENT SPONHEIMER: These are all talking points.

JUDGE FADER: It is all very, very important to earmark these issues and to present our opinion to the Legislature as to what the issues are and some of the points about how to take care of them.

SPECIAL AGENT SPONHEIMER: Also, are you going limit, are you going to provide for a secondary dissemination to those who don't have direct access to the program? Are you going limit the number of types of investigations for which reports can be used? No fugitive cases. I can't run Joe Smith because he is a fugitive and find out what address he gave the last time on a prescription report, if he is not suspected of diverting. So are you in the policy or law going to limit the number of investigations, limit it to drug diversion investigation or drug diversion and/or distribution? How is it going to be worded or structured? Are you going to require the agency to establish a policy for use and security of the reports once they are printed? Are you going to allow access

only to those agencies that have dedicated units to investigate drug diversion?

JUDGE FADER: Which do you recommend?

SPECIAL AGENT SPONHEIMER: It is something to think about.

(Laughter.)

SPECIAL AGENT SPONHEIMER: I make no recommendations, just personal opinion and talking points. Would this discriminate against smaller departments, would it require other departments to reorganize and have a cost component with it?

Another thing -- this probably should have been first. Should law enforcement even be granted access to it? I know the perception in Virginia is Maryland is a very liberal state. It is not good, bad, it is just different. I grew up in Maryland so I can understand it. And should anyone supervise the law enforcement inquiry if granted access? Who is going to do it, the Board of Pharmacy, law enforcement agent's supervisor, or a third party? I would submit that probably the Board of Pharmacy, or whoever you

house the information with, there should be a -- like in Virginia it goes down for a quick review and submit it. And what type of review or supervision should be established? Is it going to be active, you are like running every practitioner in Fairfax County, what is wrong with you. Or is it just going to be, all right, there is a complaint, when did he access this, okay.

Should insure that the information is available quickly and easily, latest physical security. Obviously should allow information to be disseminated to the practitioners and dispensers. That's the whole goal of it. Frontline people who are going to treat people who are addicted and prevent diversion are the pharmacists and the practitioners, firstly.

And I would submit, personal opinion, you should make information available to law enforcement. Whatever mechanism or restriction is put in place is going to be up to the committee and the General Assembly. I would avoid making law enforcement obtain a subpoena, search warrant, or court order to obtain

the information. Again, personal opinion. I would qualify every one of these with personal opinion.

Should keep active records of every request submitted in case there is a question.

JUDGE FADER: In Maryland, of course, some financial records and other records are privileged and the State's Attorney's Office can only get at those by an Order of Court, even for investigations of grand juries. They would come to me with a statement of facts, where I would not have to disclose so unless they get a court order. So there are some thoughts that some of these would be only on court order, and that's just something else we have to see.

SPECIAL AGENT SPONHEIMER: Should you include all substances, and other commonly abused drugs such as Soma, Tramadol, or the other ones listed there. Should you include them? That's something just to think about.

Yes, sir?

DR. COHEN: I was going to say for accuracy, being a psychiatrist, SNRIs and SSRIs are not

controlled dangerous substances.

SPECIAL AGENT SPONHEIMER: Yes, but I'm saying should you include them in reporting requirements? If it is a blanket no, then again something to think about.

JUDGE FADER: According to my wife if I knew all of the people who were taking Prozac, Zoloft and Paxil, which she's not allowed to tell me, it would be unbelievable. It seems to me that would be a burdensome situation.

DR. FARAH: I think probably ten percent of the citizens of Maryland are NOT on them.

(Laughter.)

DR. WOLF: Are they abused?

MS. KATZ: That's the question, are they diverted? For the purpose of our discussion, are we concerned about it from a clinical standpoint, the patients are abusing Cymbalta, is that the issue?

SPECIAL AGENT SPONHEIMER: Just something to think about. If it is a blanket no, we're not concerned about that, not required to be reported.

Again, just something to think about. If everyone says, Agent Sponheimer, you are out of your mind, what are you doing? Okay.

DR. MARTIN-DAVIS: Is it something that's diverted in Virginia?

SPECIAL AGENT SPONHEIMER: I've had a couple of fake scripts. It is just a point.

JUDGE FADER: You certainly got us thinking. Are you sure it is ten percent?

(Laughter.)

SPECIAL AGENT SPONHEIMER: It should be a mechanism in place to provide appropriate law enforcement training about the program. And some of that should include just what you were concerned with as well, let the physicians be physicians, let them do their job, don't interfere with patient care.

Are you going to include access to other people from bordering states? Are you going to allow Virginia physicians to access your information? Are you going to allow Virginia law enforcement to access your information?

JUDGE FADER: Are we going to try to get into a system for bi, tri, quad --

SPECIAL AGENT SPONHEIMER: Your concern last meeting is everybody is so concentrated, there should be some regional.

DR. FARAH: Yes. Pennsylvania, Virginia, Maryland, Virginia, D.C., we need to get everybody in the fold.

SPECIAL AGENT SPONHEIMER: Virginia will allow Maryland practitioners access, but they won't allow other state law enforcement.

JUDGE FADER: There is another situation with regard to money, too. If the majority of this Advisory Council would feel that the Virginia system works well, why would we want to spend $200,000 in software if we can buy yours cheaper, and things of that sort. So all those things can be considerations for the Legislature.

DR. FARAH: Because of the technical glitches and the advances in software capabilities, I think because of the advancements, your computer is

good six months. And this software is now 2006, three-year-old software. To me it is obsolete already.

JUDGE FADER: All of those things are very important. Updates inserts the word money.

DR. COHEN: I don't know who the technician --

SPECIAL AGENT SPONHEIMER: They're in the process of paying the Profarma conviction in the western district of Virginia, and the civil penalty that they paid for the mismarketing of OxyContin. That's a windfall for the State and a lot of that is going to the Prescription Monitoring Program. And with that they are printing the software to allow the dispensers and practitioners 24/7 access. With that they are improving the system for frontline patient care.

MR. CLARK: Did you contract with an outside agency to produce your software, or did you do it with the IT people within the state?

SPECIAL AGENT SPONHEIMER: I know that they

report -- the pharmacy reports to a third-party contractor. I don't know who developed that software.

DR. WOLF: Do they charge the pharmacies to enter the data?

SPECIAL AGENT SPONHEIMER: No. There is no fee associated with uploading the data to the Board of Pharmacy.

JUDGE FADER: This is one of the main reasons we have been able to get grants is because the pharmacies and the physicians particularly in this day and age need to be assured that economically they are not going to be charged with this. And Ms. Zoltani is going to talk to you later. We did get our grant request in on time and we will talk to you all about that later as to the moneys that are available, and what they are available for and when they'll be realized. We realize if we go to the physicians and tell them this is something new that you are going to have to pay for and to the pharmacies, that we're going to be in deep trouble.

MS. KATZ: Can I ask another software

question? When a pharmacist enters a script into their own system at the CVS, is there any chance that that slides into the database, or do they have to double enter?

SPECIAL AGENT SPONHEIMER: It doesn't have to be double entered. It just has to be uploaded to another server.

MS. KATZ: So it is a relatively automatic -- in other words --

JUDGE FADER: No. Somebody has to push a button. The software people, the people who administer the system, have to be able to tell them how to do that so this information is sent to another source.

MS. KATZ: CVS software people?

JUDGE FADER: Yes. And the problem is CVS may have different software than Rite-Aid, this one and that one. And that is a big problem in all computerization and information technology is conversions.

MR. KOZLOWSKI: That's why we have exchanges

in Maryland and we'll talk about those at some point. Just so everybody understands, when CVS 2067 fills a script, they don't press the button and upload anything. They're uploading to CVS, it is going to a TPA, going through an exchange, eventually getting into that system. So when they talked before about an error in the dispensing, that error very possibly was a downline error, not a frontline error, and you verify that when you went on site because their records indicate it. It is the same thing as pricing. It is not whether it is six-year-old software or four-year-old software, those errors occur. You will get it when you -- as you do review of TPAs and you go through the data sources. That's the verification reason at the end.

MS. HART: I can answer that. There are actually standards that each of the chain drug stores submit to. American Society of Automation in Pharmacy started with standards in 1995 and have updated those standards in 2007. So you would have to determine which one of those standards you wanted to put in

place and what amount of data you are willing to collect. While Virginia doesn't collect the driver's license number, certain states do request a driver's license number be transmitted. These are fields of probably a hundred data elements that you can pick and choose from to submit based on the standards.

SPECIAL AGENT SPONHEIMER: You can design the fields however you see fit.

MS. HART: There are given set standards and you can pick and choose in those standards what you want for your individual state.

SPECIAL AGENT SPONHEIMER: Just a note, public health and safety, we all know this, prescription monitoring programs can provide for early detection of drug abusers and allow physicians to intervene as they see fit.

The ultimate goal of any prescription monitoring report should not be to deter the legitimate prescribing of necessary medication. Whatever policies put in place should not hinder a physician in treating patients or be afraid to

legitimately prescribe Fentanyl or Dilaudid.

In Virginia we have a proactive notification, which means Board software monitors the reports that come in, and if a patient meets the certain criteria a letter is sent to the practitioners, saying, hey, this patient has seen four practitioners in the past month and visited four pharmacies. FYI type of thing. So the physicians can intervene as they see fit, possible indication of possible drug abuse. It may be they're referred to specialist after specialist after specialist, could be a possibility. But those notifications are not sent to law enforcement, sent to physicians only. You would receive a notice that one of your patients is seeing four other doctors, you say, okay, they're all referrals, okay, that's fine, no big deal. That's why it is just reviewed.

DR. WOLF: But there is no response requirement?

SPECIAL AGENT SPONHEIMER: That's correct. If you do have a patient you are seeing every month

who is also seeing four other physicians every month, gives an opportunity for intervention rather than criminalization of the act.

DR. WOLF: One of the interesting things we're going through right now is that one of the major generic houses the government tried to work with them because of manufacturing irregularity, and they finally just shut down all of their factories. It was FX I believe it was. And there is a nationwide shortage of a variety of different medications, be it Digoxin, but also one of them is Oxycodone. And the hospitals, the pharmacies, everywhere, and you have a patient who is a legitimate patient in a situation that needs a script filled, and they may wind up going to four or five different pharmacies because nobody has any.

SPECIAL AGENT SPONHEIMER: But the pharmacies are only going to report what is dispensed. They are not reporting attempt or --

DR. WOLF: Yeah, but this month they went to this pharmacy and next month they went to a different

pharmacy.

SPECIAL AGENT SPONHEIMER: But it is within one month.

DR. WOLF: This is within a single month?

SPECIAL AGENT SPONHEIMER: Yes, but thank you for the clarification. I should say within a given time period, one month, so thank you.

Our favorite part of the day is statistics. Number of records in the Virginia database by quarter: December 31st, 2007, 19.5 million. December 31st, '08, 31.3 million individual prescription records were in the database.

Number of requests for information submitted, pilot years, '04, '05 was very low. 2008, 43,819 requests were submitted to the Board and reports generated.

MR. KOZLOWSKI: Your previous slide, was the increase due to an increase in prescribing, or an increase in the number of pharmacies reporting in the context of -- what was the cause?

SPECIAL AGENT SPONHEIMER: I don't know. It

is cumulative. So between December 31,'07 and 4/1/08 is only 2.1 million were submitted or 3.1 million were submitted. That's the cumulative number by quarter. It is not the number for that quarter. The number is cumulative.

Percentage of requests. How much does law enforcement request, how many cops can look at this. Prescribers account for seventy-five percent of the number of requests to the Virginia PMP in 2008. Law enforcement only accounted for five percent. So the eighteen of us in the State account for five percent of the total. Pharmacists, twelve percent. And the HPIP and DEA.

This is the number of prescriptions by schedule by quarter. If you break it down anymore I would probably go insane. The total number of prescriptions received. State Police utilization only accounted for five percent of the total in 2008, which means you requested approximately 2100 prescriptions. Break that down even further, 2.4 requests per week per agent. Just to give you an example, that's about

average, two or three a week. You get a complaint from a pharmacist, open up a case. I may run two or three reports or requests on one case, because I find out they're using another name and I request that name.

DR. COHEN: Question: What kind of outcome analysis is being built into that data, outcome of follow-up? If you want to know if this is going to be an effective program because of the expense I want to know what does that mean? So I would be asking -- I would do something like a trigger every six months or every time you enter into the system every month I want to know what happened, what was the purpose of this particular use, what is the status of your completed purpose, it could be investigation, inquiry review, what actions were taken, could be prosecutions, referrals, and what were the consequences of that. Was it a positive, negative, whatever. Out of that you can start to produce profiles that will let you know who is really diverting and who isn't that will then clue in both

the practitioner, the dispenser, and the law enforcement person, who we should really be going after. My question is, is that built into the system?

SPECIAL AGENT SPONHEIMER: No.

DR. COHEN: Why not?

SPECIAL AGENT SPONHEIMER: I have no idea.

DR. COHEN: My point is what we're seeing around the country is that we're doing that may be absolutely necessary but we have no cost effectiveness. It may be we only need one case that saves us a heck of a lot of money and kills less people. But we don't know. I would strongly urge the state of Virginia and ourselves to consider that.

SPECIAL AGENT SPONHEIMER: That's a very good point. Bringing up the good points is why we're all here.

DR. COHEN: And you didn't design it.

SPECIAL AGENT SPONHEIMER: We have a central diversion unit coordinator down in Richmond who handles all our data. Every case we open we have to

send him a copy of the opening and closing report, and whether we made an arrest in the case, whether it was prosecution declined, how many dose units of drugs we identified as diverted. I don't have that information with me. If you want, I can give you a business card or I'll give you the website where you can get that information.

DR. COHEN: Thank you.

DR. LYLES: What percentage of the Virginia population is in this database?

SPECIAL AGENT SPONHEIMER: That's a good question.

DR. LYLES: You go to the dentist and get a prescription for Percocet or Percodan, something minor, are they going to be in the database, also? Eventually you are going to have basically everybody in the database, the way things look with this. That's a huge database.

SPECIAL AGENT SPONHEIMER: Absolutely.

DR. LYLES: Do you know what percentage of self-pay is in it?

SPECIAL AGENT SPONHEIMER: Method of payment doesn't matter, if it gets reported or not. It is just whether it was filled. So the number of unique records in there I have no idea. I can't speak intelligently on that.

DR. WOLF: Does it tell cost too, or doesn't it?

SPECIAL AGENT SPONHEIMER: No. That's something you would have to go to the pharmacy. As an investigator, I would have to go the pharmacy and find out the amount of the loss to the insurance company or how much they paid for it cashwise. This doesn't collect or disseminate cost data.

MS. TAYLOR: If you were to optimize the Virginia system, what changes would you suggest or make to the system that currently exists?

SPECIAL AGENT SPONHEIMER: It is kind of a good question. They're in the middle of implementing a couple of changes I would make anyway. One of the things on the report you viewed earlier just had the pharmacy and the number. On the new reports they're

going to provide the pharmacy, the number, and the address of that pharmacy. If I need to visit this pharmacy, it will tell me where to go. They're also going to include -- now it is just the name of the practitioner. The new reports will include the name and the address on file of that practitioner, and a phone number of the practitioner, too, so if we need to make the phone contact we can do that. Those are the two changes, instead of me typing up on the Internet, going to the Virginia Board of Medicine, putting a last name in, this number, he works here, I can't call him until Wednesday because he doesn't work on Tuesdays.

So those are the two things that I would put in there. Put in, include the address and the phone number of the pharmacy and of the practitioners.

MS. KATZ: Does it include the specialty, so you would know a pain management physician from a podiatrist?

SPECIAL AGENT SPONHEIMER: No. That's something we would have to go to the Board website on

that and see exactly what their license is or if they have a certified specialty.

DR. WOLF: Do you have access on the Internet to all of the different specialty boards? I believe in Maryland we can look up a physician, but if you want to look up a dentist or podiatrist or something like that, you actually have to call them because they don't have any Internet presence. And their organization isn't set up to provide that information on the Internet.

SPECIAL AGENT SPONHEIMER: Virginia does.

DR. WOLF: Virginia does? You can look at the Dental Board and Podiatry Board and all that?

SPECIAL AGENT SPONHEIMER: Not as you can the Medical Board. On the Department of Health Professions home page there is a license lookup. If you know a first name, last name, and a certification or a license number, you can look it up by that. And what that will tell you, not where they practice or anything like that, but if they have any public information, any Board notices or actions against

them.

DR. WOLF: You can only do that for physicians in Maryland.

JUDGE FADER: Pharmacists as opposed to pharmacies.

MS. BETHMAN: You can do the pharmacists. Different boards are sets up differently, but most of them you can.

JUDGE FADER: Can you do the pharmacies, Linda?

MS. BETHMAN: Not pharmacies. Just the pharmacist.

SPECIAL AGENT SPONHEIMER: In conclusion -- you should all clap now. This is a review of what I tried to cover, talking points and what I tried to bring forward, just ideas. We talked about goals and objectives, Virginia program description and overview, Virginia reporting requirements, laws and regulations in Virginia regarding that, how anybody would access the information, use of the reports, how they're secured, their design, construction, and some

statistical data.

MR. WAJDA: Do you think your job or a practitioner's job from the medical perspective would be improved by making this real-time in Virginia versus the two-week delay?

SPECIAL AGENT SPONHEIMER: It would, absolutely. I don't know how cost effective it would be. It would be up to the pharmacy, I don't know if they would upload nightly or wouldn't.

JUDGE FADER: The pharmacies, most pharmacies, have all of their data transferred someplace into the Nevada desert or Arizona desert at 2 o'clock in the morning, but how easy that would be to separate out we'll have to find out.

SPECIAL AGENT SPONHEIMER: If you are talking about like twenty-four hours a day access, I don't need that. I can wait until the morning to run a report.

MR. WAJDA: The 24/7 access isn't the issue, it is the 24/7 real-time data, the data input that's the issue I think.

JUDGE FADER: Your data is available to you 24 hours a day?

SPECIAL AGENT SPONHEIMER: No, no. I can only request and receive reports Monday through Friday 8:15 to 4. Soon it is going to come to the dispensers and practitioners can access it 24/7, within one or two minutes, but that information they receive will be up to two and a half weeks behind.

DR. FARAH: I have a general question, and I don't know, this has been going on for a few years. Do we know if it has risen to the level of a standard of care that the practitioner would be expected to look at information like this before prescribing to patients? Are we getting close to a point where the expectation is going to be that pain management doctors, or family doctors, or oncologists, or orthopedics are going to have to really look before they actually prescribe?

JUDGE FADER: There are no reported cases on point. There is an organization, the American Society of Pharmacist Attorneys, and I see nothing that

they've had come through and I have seen nothing come through from any of the pharmacists liability carriers that have indicated that this has said it is going to be part of the standard of care yet. But some enterprising lawyer will try to do that.

DR. LYLES: Some of the carriers now, if you have an EMR system, what you see when you write a prescription is that someone else has written that prescription, it will come up in your database, that the prescription was written two days ago and it has been prescribed.

DR. FARAH: I guess that will make sense.

DR. LYLES: If you participate with certain carriers pharmacy benefit manager's data.

DR. FARAH: I get that from High Mark and Express Scripts. They want to know does your patient receive, blah, blah, blah.

DR. LYLES: Now we have that in real time. I can get it when I write a prescription.

JUDGE FADER: Let's be aware that all of this is for legislative discussion. We have in place

the psychiatric/psychological privilege and social worker privilege. They are absolute. I must handle ten different requests each month from people, domestic cases, trying to get into that access. And the answer is no. You just can't get in there. So the Legislature has it within their ability to do whatever they want with this, including a shutoff as they do with psychiatric records.

SPECIAL AGENT SPONHEIMER: Same stuff we talked about just to see it again in review. Real quick. Any other questions?

JUDGE FADER: I have a question. Is there anyone here who thinks that LaRai Forrest could have picked anybody any better? Thank you very, very, very much.

(Applause.)

DR. FARAH: He is a Maryland resident, that's why he is so good.

JUDGE FADER: But I can tell you that we will be calling on you. I rather suspect that we will, some of us, be coming down to look at your

system in place and we could not be more appreciative of your experience and your presentation.

I have a little teeny business to do with you, and then we do want to keep our faith with you to get you out of here. We have for the April 17th meeting scheduled the databases. And Bob Lyles and I met in Annapolis a couple of weeks ago, we put together just a format. We now want to meet with the other members of this committee for databases, which is Bob Lyles, Ann Taylor, Marcia Wolf at breakfast some morning within the next two to three weeks, two weeks preferably weeks, somewhere in between, at 7:30 in the morning. Bruce, make me happy and tell me you will be a part of this.

MR. KOZLOWSKI: Either myself or Dr. Sharp.

JUDGE FADER: Whatever it is it wouldn't be a good party without you. And the situation is, is there anyone else that wants to be part of the presentation that we anticipate making on April 17th, these are the databases, these are available, this is what can happen, and things like that. Anybody else

that wants to be included in this breakfast?

(No response.)

JUDGE FADER: So I will send Bob's report and a summary of our conversation out within the next couple of days after the first of the week to everyone and try to get a suggestion for a date to meet with regard to that.

MS. ZOLTANI: Judge, by the way, the April 17th meeting, Gail was kind enough to offer her place for us to meet, which is out in White Marsh, The Cancer Center. Would anybody have any problems with that?

MS. KATZ: Free coffee and free parking.

JUDGE FADER: Pretty easy to get to off of 95?

MS. KATZ: And I will send directions.

MS. ZOLTANI: And I'll be sending them out.

JUDGE FADER: Okay. The University of Maryland Law School has one of the best, always, rated healthcare law programs in the United States of America. Professor Diane Hoffman, who is one of our

associate deans, and I have talked considerably about this and she feels that the school is in the position to now give us some research help, that they will pay for, for some students to pick up statutes that we want to analyze and information that we want to obtain. It just seems to me personally to throw it out to you that we really can't get involved with any more than five or six of these different statutory schemes. I don't know. I have Kentucky and Virginia on here. If anybody wants to object to them, fine. If anyone else wants to talk about what these law students are going to do with assembling the statutes, any annotations under it, anything else that is available, to go into the states with reports from that state, for LexisNexis, all these things. Maryland has two people, Maxine Grosshans and another individual, that do nothing but give assistance to faculty members with regard to publications on various things. So the availability of this, comments, things of this sort. So with this agreement to work for this, we're going to pick up some pretty sharp

students with some pretty good library help.

MR. WAJDA: I believe there is at least one organization that has a model, PDMP Law, that can be downloaded and used as a reference as well. It covers a whole lot of the things that we talked about or looked at today.

JUDGE FADER: I just ask all of you to understand, I don't have sufficient familiarity with these systems. I just need some states. Everybody seems to mention Kentucky. What is that called, Mike?

MR. WAJDA: It is a model. PDMP Statute. I don't have the organization.

DR. WOLF: I actually have the statute on my computer if you would like a copy of it.

JUDGE FADER: Marcy, do you think that's something that's worth going into, articles written on it, criticisms, things of that sort?

DR. WOLF: They discuss the different systems that some of the different states have, and then what they would see as an ideal version of a

PDMP.

JUDGE FADER: Would you send that to me?

MS. KATZ: There is also an organization called the Alliance of State Pain Initiatives, and they've done analysis of a lot of these, also. They are out of the University of Wisconsin.

DR. WOLF: There is a new report that just came out, too.

JUDGE FADER: Can you give me their information? I can ask them what states they feel we should take a look at. Ann, you have talked to me about this a couple of times, what do you think would be some good state to take a look at?

MS. TAYLOR: I think New York is also another good state. I have a list actually of the states. We actually had a list of the states and you can take a look at the states that have had their programs in operation for some time, and also look at the state that does not have their program in operation and determine why, to see what it was that caused them to not go to operation on it.

JUDGE FADER: Let me say this, by the Ides of March, I would like to send an e-mail to everybody saying we suggest these are the states or the organizations that we look at. I so far have Kentucky, Virginia, New York, Model PDMP, Alliance of Pain Initiatives. We'll contact them and ask them. But can everybody just send to everybody else, considering this I think we should add this state for this reason or that reason, and then we'll all talk about it and choose five or six, subject to the overwhelming majority of people coming in and saying no, strike out so and so and put such and such on there.

DR. WOLF: Hawaii actually has a very, very good system.

JUDGE FADER: Can I go out there and investigate? Kendi wants to come with me.

(Laughter.)

DR. WOLF: It is very real-time. The problem is they operate in a vacuum because they're landlocked basically. People are not going there for

prescriptions in California and other places. They have an excellent system.

DR. FARAH: Judge, I have a new business on funding which I would like to bring to your attention.

JUDGE FADER: First of all, we have the subcommittee for that, that we'll get out of the way and hope for a presentation on April 17th. Then I'm going to send out by the Ides of March a statement that is saying it seems to me the collective thought is, and may I have any -- and why the collective thought, for instance Kentucky has been around the longest, such and such, and Virginia. We sure know they have a real good system. We need to go down and take a look at that, and the rest of the stuff, and then we'll invite comments back before we see.

And now, you want to talk about one of the favorite things that lawyers want it talk about is money.

DR. FARAH: Yes. Maryland is one of the few states that require a special license for controlled dangerous substances in addition to the DEA standard

license that every state requires.

JUDGE FADER: That's up for repeal.

DR. FARAH: And my feeling is that instead of having a controlled dangerous substance permit, which is a duplication of costs, is that these funds be used to support an initiative like we're doing here.

JUDGE FADER: Well, somebody and I can't remember, Bob, whether it was you or who told me, that there is a bill in the Legislature to do away with that because it costs $220 a year or something of that sort for the physicians.

MS. ZOLTANI: $120 for two years. I think they bring in about 1.8 million a year.

JUDGE FADER: Would you all let us know when that is coming up before the Legislature?

DR. LYLES: It may have already been heard in either the House or the Senate, I'm not certain.

DR. WOLF: That is another tax on the physician.

DR. FARAH: It is already being paid.

DR. WOLF: But when the costs go up, the fee is going to go up. If you switch that funding to the PDMP, then when the cost of the PDMP goes up, the price of the license is going to go up.

DR. LYLES: The thought was the DEA already does this, why do we need to do this.

DR. FARAH: We don't, and many states don't. We're one of the few states that do.

DR. LYLES: What you are proposing may be something that we want to look at in the future as a different approach.

JUDGE FADER: It is going to be very, very hard once that fee is taken off to put it back again. If we're going to have to do something for the Legislature to say would you hold this so we can take a look at this. Do you know how much money that brings in every year?

MS. ZOLTANI: About 1.8 million.

MS. BETHMAN: That only affects prescribers. Distributors, researchers get CDS permits. The bill only affects prescribers.

JUDGE FADER: If you can find out how much it would affect prescribers. I don't know if there is any way to find out.

MS. KATZ: Does it have a specific use?

DR. LYLES: General fund.

MS. ZOLTANI: It goes to the General Fund, and the 1.8 million is prescribers and establishments.

JUDGE FADER: So the 1.8 is prescribers and establishments.

MS. ZOLTANI: Practitioners and establishments, not prescribers.

JUDGE FADER: What is your position, do you think we ought to do away with it?

DR. FARAH: There is really no reasonable justification of why we have a duplicity.

JUDGE FADER: But the reason may be coming up.

DR. FARAH: That is the reason why I was thinking that if we don't have -- we right now have an unfunded mandate pretty much, and if we're thinking of how we're going to get the money, this is one venue to

consider. I mean, just food for thought.

JUDGE FADER: What is the medical societies' view on that?

DR. WOLF: Is that part of this relationship with physicians that dispense?

MS. BETHMAN: No.

JUDGE FADER: It is part of the your budget?

MS. ZOLTANI: No, no, no. It has nothing to do with Drug Control's budget. All of that money goes into the General Fund.

DR. FARAH: Is there a reason for that license as we see it today? There are only a handful of states that do that.

MR. WAJDA: Fifty percent of the states.

DR. LYLES: This is a hassle factor for the physicians. It is not the $120 per se. It is the hassle, you might forget to fill it out and then you have a problem with the license. Why have something like this that's such an imposition. Just get rid of it if you don't need it.

JUDGE FADER: The long and short of it is, this may go into the General Fund, but one of the reasons that Georgette's office is funded has to do with the realization that that money is coming in; is that correct?

MR. WAJDA: I think that there may be that concept, but it is not diverted to Georgette's program.

JUDGE FADER: I understand that, but we're talking about realistic concepts.

MS. KATZ: I think what you are talking about is if we were to come back to the Legislature and say we need a PMP exactly like Virginia and it costs 1.8 million dollars a year, we could then suggest that that money that is already coming in --

DR. FARAH: Be earmarked.

JUDGE FADER: Bob, if you can send me a copy of that bill and then we can all talk and report to the Advisory Council and see if they want to take a position on this.

DR. LYLES: Sure.

MS. ZOLTANI: There are only three people out of my office. It is not like if they're going to do away with CDS and then we have to close our office. It is not. There are only three people who deal with the CDSs. The rest are investigations.

JUDGE FADER: How many people in your office?

MS. ZOLTANI: Right now there are nine.

JUDGE FADER: Nine, okay.

DR. LYLES: I would say it is probably going to die. This is not the year that -- it is just not going to happen.

DR. FARAH: You see, I would hate, if the feeling is -- I don't remember what the Board -- I think the Board didn't feel there was a need for an additional license. I don't think there was a purpose. I don't want to speak for the Board because I don't remember that. I feel because of time, and everything is like time, it makes sense to say okay, let's switch this to this, divert it, and everybody keeps their job.

JUDGE FADER: Let me try to obtain as much information, find out what the status of the bills are -- what committee is that in, health and education?

DR. LYLES: Economics.

JUDGE FADER: Is that Peter Hammond?

MS. BETHMAN: Yes. It is House Bill 229.

JUDGE FADER: Do you think it is going to go anywhere, Linda?

MS. BETHMAN: You are dealing with money. It is a lot of money that comes into the State.

JUDGE FADER: She doesn't think it is going to go anywhere. Let me look into this and talk to Linda, and Bob, and Ramsay, and see if we can get some type of physician paper up on it. I sure would hate to see a source of funds like that go away with this important program and then we come back to the State next year and try to get some additional money.

DR. FARAH: Knock on the door, we need money.

MS. ZOLTANI: You can't do away with the system just for the money. It wouldn't make any

sense.

DR. LYLES: How would you feel about doing away with the hassle factor for the docs? A number of physicians, one year the State didn't send out the applications, a lot of docs were caught and couldn't write prescriptions.

DR. WOLF: They had something on the web that we could download. It was a temporary fix.

JUDGE FADER: This is a problem that I have had for years with the Board of Pharmacy, that they send out a notice about renewing things, and they don't then follow up on it. And we are in a nanny society where everybody wants to be taken care of. And the question is, is there somebody, is there a thought process that they need to spit out another notice. I don't know what the physicians do. Do you spit out another notice?

DR. FARAH: No. We send out one notice, and then we put in our bulletin, remember.

JUDGE FADER: The Board of Pharmacy have had a number of pharmacists who have been practicing over

the years and who have not renewed their license, which means they're violating the law, subject to a criminal penalty. And we'll have to talk about that with regard to the hassle.

DR. WOLF: One of the other things is a hassle is you can't renew it online. It has got to be done on paper.

JUDGE FADER: Okay. We'll have to -- it is another thing we have to think about.

DR. LYLES: In Virginia I can do it online.

SPECIAL AGENT SPONHEIMER: I tried.

MS. ZOLTANI: I've been wanting to do that to put it online. And I thought it would work real fast, I had all the information, but it is money. They didn't have the money.

DR. MARTIN-DAVIS: But you can get the application online?

MS. ZOLTANI: Yes, the application is online.

DR. WOLF: For renewal or for new?

MS. ZOLTANI: It is the same. It is

online. It is on the web.

JUDGE FADER: Now, lastly, I had hoped that in May -- I mean, in June, that we could hear from the pain community, but Gwenn has told me that you all have a big meeting in June?

MS. HERMAN: Yes.

JUDGE FADER: When is that going to be?

MS. HERMAN: June 11th to the 14th in Minneapolis.

JUDGE FADER: Is there any chance, then, by the 27th, Gail and June, Gwenn, if we would put the pain presentation, your positions, your war stories, your important people that have come in and say how they've been hurt with this, on the 27th of June?

MS. KATZ: I definitely will not be available on the 27th of June. It is a sacred week to my family.

JUDGE FADER: How about the 20th?

MS. KATZ: That's not sacred.

MS. FORREST: The 20th is a Saturday.

JUDGE FADER: I mean the 19th.

MS. HERMAN: I'm going away.

JUDGE FADER: I'm trying to do these every six or seven weeks.

MS. KATZ: How about if we went to the week before, June 4th?

MS. HERMAN: June 5th.

JUDGE FADER: All these weeks are okay with me. I'm asking, do you think you could be ready by then?

MS. KATZ: Yes, yes.

JUDGE FADER: What do you think everybody? Anybody have any objection to June 5th?

(No response.)

JUDGE FADER: Gwenn, can you get together with Gail?

MS. KATZ: We already have it set up.

JUDGE FADER: And do this and then can we all get together sometime around the end of April, with me and all of you, and talk about the presentation that is going to be made there?

DR. MARTIN-DAVIS: Our next meeting is April

17th?

JUDGE FADER: Our next meeting is April 17th, and the meeting after that is June 5th.

Now, we are going to then start sometime before the end of March in assembling all of these statutes that you want to look at. That will mean that we will have a fact sheet sent out to you as issues, and then we will show how this statute treated this issue, how this one did, how that one did, what all your comments are on this, so the statutes will be in an exhibit and then we will give a synopsis plus page numbers as to where you can find what a particular state did with this or did with that and then the comments of people. So that is my opinion how all of that should be put forth, but I want to know what you think. I can't think of any other way to do it. Here are the issues, here are the statutes, here are the articles written saying this is wrong, here are the articles written saying this is right. Anybody else got any ideas?

DR. WOLF: I would actually like to see some

real data from some of these states that have been in existence longer.

JUDGE FADER: The law students will be making calls about obtaining whatever data we have available, things of that sort, to include in this. But they -- and Maxine Grosshans from the School of Law, the stuff she gets for me when I send her an e-mail and say Maxine, can you do this and do that, boy, I'm telling up, zap, zap, zap, zap. She probably is going to be -- and the law school maintains those people, there are two of them that just do that. They're very talented, but we will do that also.

DR. LYLES: We would like to know if these systems are effective.

JUDGE FADER: And we want all the criticisms on the systems. What you have to do is you have to -- what I would like to do is to contact the State people that run the system and say how are things going. Then I want to contact the Attorney Generals who are responsible for enforcing them and say how is it going. Then I want to pick up some lawyers whose

business is to attack the Attorney General's Office, and to say -- and to find out how they feel that it is going. But I just can't think we can get into that for more than five or six different types of systems. But you can take these cases and Attorney General's Office has litigated this and you can run LexisNexis and find out who the attorneys are that are on the other side that have been fighting the Board or the Attorney General in court hearings and things like that and say, hey, can you tell me anything, are there any articles here and then we can get it all together and see what the situation is.

MS. KATZ: There is one I think and it could be Tennessee.

JUDGE FADER: Somebody else told me something good about Tennessee.

MS. KATZ: That implemented it and then when the federal funds ran out that supported it originally, they stopped it. I think that's worth investigating. It may have simply been a budget decision or may have decided the cost benefit wasn't

there.

JUDGE FADER: Once again, I would like to have as many emails from as many different people with as many versions and visions for all these systems as possible. I think we ought to look at this, I think we ought to look at that. And then we will send out to you what we think and why by March 15th -- what day of the week is March 15th, whatever it is. It is one of my favorite days in life with the description of the great Caesar, stuck 23 times --

DR. WOLF: It is a Sunday, because Friday is the 13th.

JUDGE FADER: -- pulling up his robe so that they would not see him writhing in pain. Psychiatrically what does that make me?

DR. FARAH: Saint.

MR. MOONEY: I would like it two days after that.

MR. CLARK: I think two days after that is a better date.

JUDGE FADER: The 17th? Be happy to take

care of you, me boy. I used to sit in court and make a mistake sometimes to schedule cases, and I would sometimes do it on March 15th -- March 17th, and some Irish lawyer would say, Judge, that's my high holy day, believe me, you do not want me in court.

It will be the 17th, St. Patty's Day. All right. Thank you all very much. Marcy?

DR. WOLF: Is there any mechanism for going over the minutes? There were some inaccuracies, mistakes within the minutes of the previous meeting. I just don't know if these are going to come back to haunt us.

JUDGE FADER: Would you please communicate that to Georgette and see what she has to say? The minutes, remember, are a reflection of the transcript.

DR. WOLF: I understand the reflection. In fact, I sent one to Ms. Zoltani that showed her the transcript and what the minutes said. And I think Dr. Lyles also has one. They're misquoted.

MS. ZOLTANI: I already forwarded.

JUDGE FADER: Georgette asked me this

morning, had I seen your comment. Yes. She said, have you read it, I said no. So I will read it and find out what the situation is. If anybody else has any comments, that's fine. But let's go.

(Whereupon, the meeting was adjourned.)